JS 44 (Rev. 12/12)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS
Raul Delgado

(b) County of Residence of First Listed Plaintiff Philadelphia
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, and Telephone Number)*
Dana H. Augustine, Esquire
The Beasley Firm, LLC, 1125 Walnut Street, Philadelphia, PA 19107
(215) 592-1000

DEFENDANTS
United States of America

County of Residence of First Listed Defendant Philadelphia
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*
James C. Sinwell, Esquire
U.S. Dept. of Veterans Affairs, 1010 Delafield Road, Pittsburgh, PA 15215 (412) 822-1584

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ☐ 1 U.S. Government Plaintiff
- ☐ 3 Federal Question *(U.S. Government Not a Party)*
- ☒ 2 U.S. Government Defendant
- ☐ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*
(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☐ 1	☐ 1	Incorporated *or* Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

CONTRACT
- ☐ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment & Enforcement of Judgment
- ☐ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans)
- ☐ 153 Recovery of Overpayment of Veteran's Benefits
- ☐ 160 Stockholders' Suits
- ☐ 190 Other Contract
- ☐ 195 Contract Product Liability
- ☐ 196 Franchise

REAL PROPERTY
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

TORTS

PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury
- ☒ 362 Personal Injury - Medical Malpractice

PERSONAL INJURY
- ☐ 365 Personal Injury - Product Liability
- ☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

CIVIL RIGHTS
- ☐ 440 Other Civil Rights
- ☐ 441 Voting
- ☐ 442 Employment
- ☐ 443 Housing/ Accommodations
- ☐ 445 Amer. w/Disabilities - Employment
- ☐ 446 Amer. w/Disabilities - Other
- ☐ 448 Education

PRISONER PETITIONS

Habeas Corpus:
- ☐ 463 Alien Detainee
- ☐ 510 Motions to Vacate Sentence
- ☐ 530 General
- ☐ 535 Death Penalty

Other:
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Condition
- ☐ 560 Civil Detainee - Conditions of Confinement

FORFEITURE/PENALTY
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 690 Other

LABOR
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor/Management Relations
- ☐ 740 Railway Labor Act
- ☐ 751 Family and Medical Leave Act
- ☐ 790 Other Labor Litigation
- ☐ 791 Employee Retirement Income Security Act

IMMIGRATION
- ☐ 462 Naturalization Application
- ☐ 465 Other Immigration Actions

BANKRUPTCY
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

PROPERTY RIGHTS
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 840 Trademark

SOCIAL SECURITY
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

FEDERAL TAX SUITS
- ☐ 870 Taxes (U.S. Plaintiff or Defendant)
- ☐ 871 IRS—Third Party 26 USC 7609

OTHER STATUTES
- ☐ 375 False Claims Act
- ☐ 400 State Reapportionment
- ☐ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce
- ☐ 460 Deportation
- ☐ 470 Racketeer Influenced and Corrupt Organizations
- ☐ 480 Consumer Credit
- ☐ 490 Cable/Sat TV
- ☐ 850 Securities/Commodities/ Exchange
- ☐ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 893 Environmental Matters
- ☐ 895 Freedom of Information Act
- ☐ 896 Arbitration
- ☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- ☐ 950 Constitutionality of State Statutes

V. ORIGIN *(Place an "X" in One Box Only)*

☒ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from Another District *(specify)* ☐ 6 Multidistrict Litigation

VI. CAUSE OF ACTION
Cite the U.S. Civil Statute under which you are filing *(Do not cite jurisdictional statutes unless diversity)*:
28 U.S.C. §2671, et seq.; 28 U.S.C. §1346(b)(1),
Brief description of cause:
Medical Malpractice at Philadelphia VA Medical Center

VII. REQUESTED IN COMPLAINT: ☐ CHECK IF THIS IS A CLASS ACTION UNDER RULE 23, F.R.Cv.P. DEMAND $

CHECK YES only if demanded in complaint:
JURY DEMAND: ☒ Yes ☐ No

VIII. RELATED CASE(S) IF ANY *(See instructions)*: JUDGE _____ DOCKET NUMBER _____

DATE
04/12/2016

SIGNATURE OF ATTORNEY OF RECORD

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____

UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF PENNSYLVANIA — DESIGNATION FORM to be used by counsel to indicate the category of the case for the purpose of assignment to appropriate calendar.

Address of Plaintiff: Raul Delgado, 6617 Charles Street, Apartment 27, Philadelphia, PA 19135

Address of Defendant: U.S. Dept. of Veterans Affairs, VA Pittsburgh Healthcare System, 1010 Delafield Road, Pittsburgh, PA 15215

Place of Accident, Incident or Transaction: Philadelphia VA Medical Center
(*Use Reverse Side For Additional Space*)

Does this civil action involve a nongovernmental corporate party with any parent corporation and any publicly held corporation owning 10% or more of its stock?
(Attach two copies of the Disclosure Statement Form in accordance with Fed.R.Civ.P. 7.1(a)) Yes☐ No☒

Does this case involve multidistrict litigation possibilities? Yes☐ No☒

RELATED CASE, IF ANY:
Case Number: _____ Judge _____ Date Terminated: _____

Civil cases are deemed related when yes is answered to any of the following questions:

1. Is this case related to property included in an earlier numbered suit pending or within one year previously terminated action in this court? Yes☐ No☒
2. Does this case involve the same issue of fact or grow out of the same transaction as a prior suit pending or within one year previously terminated action in this court? Yes☐ No☒
3. Does this case involve the validity or infringement of a patent already in suit or any earlier numbered case pending or within one year previously terminated action in this court? Yes☐ No☒
4. Is this case a second or successive habeas corpus, social security appeal, or pro se civil rights case filed by the same individual? Yes☐ No☒

CIVIL: (Place ✔ in ONE CATEGORY ONLY)

A. *Federal Question Cases*:
1. ☐ Indemnity Contract, Marine Contract, and All Other Contracts
2. ☐ FELA
3. ☐ Jones Act-Personal Injury
4. ☐ Antitrust
5. ☐ Patent
6. ☐ Labor-Management Relations
7. ☐ Civil Rights
8. ☐ Habeas Corpus
9. ☐ Securities Act(s) Cases
10. ☐ Social Security Review Cases
11. ☒ All other Federal Question Cases
(Please specify) Federal Tort Claims Act

B. *Diversity Jurisdiction Cases*:
1. ☐ Insurance Contract and Other Contracts
2. ☐ Airplane Personal Injury
3. ☐ Assault, Defamation
4. ☐ Marine Personal Injury
5. ☐ Motor Vehicle Personal Injury
6. ☐ Other Personal Injury (Please specify)
7. ☐ Products Liability
8. ☐ Products Liability — Asbestos
9. ☐ All other Diversity Cases
(Please specify) _____

ARBITRATION CERTIFICATION
(*Check Appropriate Category*)

I, Dana H. Augustine, counsel of record do hereby certify:

☒ Pursuant to Local Civil Rule 53.2, Section 3(c)(2), that to the best of my knowledge and belief, the damages recoverable in this civil action case exceed the sum of $150,000.00 exclusive of interest and costs;

☐ Relief other than monetary damages is sought.

DATE: 4/12/16 Dana H. Augustine 81276
Attorney-at-Law Attorney I.D.#

NOTE: A trial de novo will be a trial by jury only if there has been compliance with F.R.C.P. 38.

I certify that, to my knowledge, the within case is not related to any case now pending or within one year previously terminated action in this court except as noted above.

DATE: 4/12/16 Dana H. Augustine 81276
Attorney-at-Law Attorney I.D.#

CIV. 609 (5/2012)

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

CASE MANAGEMENT TRACK DESIGNATION FORM

Raul Delgado	:	CIVIL ACTION
v.	:	
United States of America	:	NO.

In accordance with the Civil Justice Expense and Delay Reduction Plan of this court, counsel for plaintiff shall complete a Case Management Track Designation Form in all civil cases at the time of filing the complaint and serve a copy on all defendants. (See § 1:03 of the plan set forth on the reverse side of this form.) In the event that a defendant does not agree with the plaintiff regarding said designation, that defendant shall, with its first appearance, submit to the clerk of court and serve on the plaintiff and all other parties, a Case Management Track Designation Form specifying the track to which that defendant believes the case should be assigned.

SELECT ONE OF THE FOLLOWING CASE MANAGEMENT TRACKS:

(a) Habeas Corpus – Cases brought under 28 U.S.C. § 2241 through § 2255. ( )

(b) Social Security – Cases requesting review of a decision of the Secretary of Health and Human Services denying plaintiff Social Security Benefits. ( )

(c) Arbitration – Cases required to be designated for arbitration under Local Civil Rule 53.2. ( )

(d) Asbestos – Cases involving claims for personal injury or property damage from exposure to asbestos. ( )

(e) Special Management – Cases that do not fall into tracks (a) through (d) that are commonly referred to as complex and that need special or intense management by the court. (See reverse side of this form for a detailed explanation of special management cases.) ( )

(f) Standard Management – Cases that do not fall into any one of the other tracks. (X)

4/12/16		Dana H. Augustine, Esquire
Date	**Attorney-at-law**	**Attorney for** Plaintiff
(215) 592-1000	(215) 592-8360	Dana.Augustine@beasleyfirm.com
Telephone	**FAX Number**	**E-Mail Address**

(Civ. 660) 10/02

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

RAUL DELGADO	:	
	:	**CIVIL ACTION NO.**
Plaintiff,	:	
vs.	:	
	:	
UNITED STATES OF AMERICA	:	
	:	**JURY TRIAL DEMANDED**
Defendant.	:	
	:	

PLAINTIFF RAUL DELGADO'S COMPLAINT AGAINST DEFENDANT, UNITED STATES OF AMERICA

Plaintiff, Raul Delgado ("Delgado"), by and through his attorneys, The Beasley Firm, brings this Complaint in Civil Action against the United States of America, and in support thereof alleges as follows:

PREAMBLE

It was President Abraham Lincoln's words from his second inaugural address that became the credo of the U.S. Department of Veteran Affairs and its hospitals "to care for him who shall have borne the battle." This is a medical malpractice action against the United States of America by Plaintiff, Raul Delgado, United States Army Veteran.

PARTIES

Plaintiff, Raul Delgado, is an adult individual and resides at 6617 Charles Street, Apartment 27, Philadelphia, PA 19135.

1. The U.S. Department of Veterans Affairs was established as an independent agency of the Defendant, United States of America (hereinafter "United States"), in 1930 and elevated to a Cabinet agency on March 15, 1989.

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2. The U.S. Department of Veteran Affairs, through its Veterans Health Administration, operates medical facilities throughout the United States, including the Philadelphia VA Medical Center where the alleged medical malpractice took place.

3. Defendant, United States, by and through its agency, the U.S. Department of Veteran Affairs, hired, retained, contracted with, supervised, controlled and is responsible for physicians, nurses, and other health care providers including the physicians, nurses, and other health care providers involved in the care and treatment of Raul Delgado at the Philadelphia VA Medical Center.

JURISDICTION AND VENUE

4. This Court has jurisdiction as the claims herein are brought against the Defendant pursuant to the Federal Tort Claims Act (28 U.S.C. §2671, *et seq.)* and 28 U.S.C. §1346(b)(1), for money damages as compensation for personal injuries caused by the Defendant's negligence.

5. Venue is proper within this district under 28 U.S.C. §1402(b) as the acts complained of occurred in the Eastern District of Pennsylvania.

NOTICE

6. On or about July 15, 2014, Plaintiff, Raul Delgado, timely filed an executed Standard Form 95 form with the Department of Veterans Affairs, Office of Regional Counsel, thereby timely making an administrative claim for damages and injuries consistent with the Federal Tort Claims Act, 28 U.S.C. §2671 *et seq*. A true and correct copy of the form is attached hereto as Exhibit "A".

7. On or about July 22, 2014, the Office of Regional Counsel for the Department of Veteran Affairs acknowledged receipt of the service of the claim. A true

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and correct copy of the letter from the Office of Regional Counsel is attached hereto as Exhibit "B".

8. On October 23, 2015, the Office of Regional Counsel issued a formal denial of the Plaintiff's claim reporting that their investigation concluded that "the standard of care was followed by Mr. Delgado's clinicians at the Philadelphia VAMC in providing for his care and treatment." A true and correct copy of the letter from the Office of Regional Counsel is attached hereto as Exhibit "C".

9. This Complaint is timely, pursuant to 28 U.S.C. §2401, as it is filed within six months of the formal denial of Plaintiff's claim

10. Plaintiff has exhausted all necessary administrative remedies prior to bringing this action, thus vesting jurisdiction in this Court.

FACTS

11. Raul Delgado entered the United States Army in or around August 1966, served as a supply sergeant in Vietnam, and was honorably discharged in or around August 1968

12. In 2010, Mr. Delgado sought medical care at the Philadelphia VA Medical Center.

13. On or about December 9, 2010, Mr. Delgado underwent a colonoscopy at the Philadelphia VA Medical Center which revealed a rectal mass.

14. On or about December 20, 2010, Mr. Delgado underwent a repeat colonoscopy, at which time the mass was partially removed and biopsied.

15. Mr. Delgado was diagnosed with adenocarcinoma, a malignant rectal tumor.

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16. Plaintiff, Mr. Delgado, underwent a full body PET-CT scan at the Philadelphia VA Medical Center on December 21, 2010 which showed the known cancerous lesion in the colon, but no local or distant metastases to other parts of Plaintiff's body.

17. The Philadelphia VA Medical Center's "tumor board" determined that the Plaintiff should undergo neoadjuvant chemotherapy and radiation therapy ("chemoradiation") before he would undergo surgical resection of the tumor.

18. Mr. Delgado completed the neoadjuvant chemoradiation on April 7, 2011.

19. The Philadelphia VA Medical Center performed a third PET-CT scan on May 11, 2011, purportedly for the purposes of cancer re-staging to determine the effect of the chemoradiation and inform a strategy for further treatment.

20. The PET-CT scan of May 11, 2011 revealed a lesion on Mr. Delgado's liver.

21. The Philadelphia VA Medical Center physicians, nurses and medical staff acting on behalf of Defendant United States knew or should have known that the Plaintiff's medical condition required immediate action and close follow-up.

22. The Philadelphia VA Medical Center physicians, nurses and medical staff acting on behalf of Defendant United States knew or should have known that failure to take immediate action and closely monitor the Plaintiff's medical condition would cause the disease to progress and spread.

23. The Philadelphia VA Medical Center physicians, nurses and medical staff acting on behalf of Defendant United States knew or should have known that failure to take immediate action and closely monitor the Plaintiff's medical condition would cause

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Plaintiff to undergo multiple diagnostic evaluations which would have been unnecessary in the absence of Defendant's negligence.

24. The Philadelphia VA Medical Center physicians, nurses and medical staff acting on behalf of Defendant United States knew or should have known that failure to take immediate action and closely monitor the Plaintiff's medical condition would cause Plaintiff to undergo procedures, tests, studies, therapies, treatments, and surgeries directed to his injuries, which would have been unnecessary in the absence of Defendant's negligence.

25. The Philadelphia VA Medical Center physicians, nurses and medical staff acting on behalf of Defendant United States knew or should have known that failure to take immediate action and closely monitor the Plaintiff's medical condition would cause Plaintiff to suffer side effects of procedures, tests, studies, treatments, and surgeries which would have been unnecessary in the absence of Defendant's negligence.

26. The Philadelphia VA Medical Center physicians, nurses and medical staff acting on behalf of Defendant United States knew or should have known that failure to take immediate action and closely monitor the Plaintiff's medical condition would cause Plaintiff an increased risk of progression of his disease, spread of his disease, recurrence of his disease, increased risk of death from his disease, and decreased chance of survivability.

27. On May 24, 2011, Mr. Delgado was cleared for the post-chemoradiation surgery by cardiology at the Philadelphia VA Medical Center.

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28. On the same date, May 24, 2011, Mr. Delgado was seen by Sandra L. Hayes, CRNP at a surgical oncology follow-up appointment where Ms. Hayes reported the following plan for Mr. Delgado's further care:

> PLAN:
> -Consult GI for EUS >depth of invasion is needed to plan surgergical approach.
> -Non VA Fee Basis consult for Colorectal Surgery Evaluation
> -Will present case @ Tumor Board for consensus on management of liver lesion.

See page 1100 of the Philadelphia VA Medical Center's Progress Notes. A true and correct copy of the complete entry for the subject date, pages 1097-1100, is attached hereto as Exhibit "D".

29. On June 9, 2011, Mr. Delgado underwent an endoscopic ultrasound (EUS) and a flexible sigmoidoscopy procedure performed by John Lieb, M.D., an employee and agent of the Philadelphia VA Medical Center and Defendant, United States. Dr. Lieb concluded that Plaintiff should follow-up with medical oncology and surgery services per his finding described below:

> There was some residual 8mm by 8 mm or so of what looked to be sessile adenoma. There was also some hyperplasia in the area, likely radiation effects. I elected not to biopsy because I do not think that would affect decision-making regarding surgery.

See pages 1084-1085 of the Philadelphia VA Medical Center's Progress Notes. A true and correct copy of the complete entry for the subject date, pages 1084-1085, is attached hereto as Exhibit "E".

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30. On June 16, 2011, Plaintiff was seen by Dr. Keerthi Gogineni, an employee and agent of the Philadelphia VA Medical Center and Defendant, United States, who noted that it was 9 weeks post completion of neo-adjuvant chemoradiation and questioned the Philadelphia VA Medical Center's failure to set a surgery date for Plaintiff.

31. On July 7, 2011, Plaintiff reported to the Philadelphia VA Medical Center Emergency Department. Dr. Grace Nejman, an employee and agent of the Philadelphia VA Medical Center and Defendant, United States, noted in the Plaintiff's records:

> Patient has completed his radiation therapy and chemotherapy. He is waiting for an approval to see the surgeon at the University of Pennsylvania. To this date he has not been scheduled for his operation.

See page 1062 of the Philadelphia VA Medical Center's Progress Notes. A true and correct copy of the complete entry for the subject date, pages 1061-1064, is attached hereto as Exhibit "F".

32. On July 7, 2011, Sunny J. Haft, a medical student, noted the plan for Plaintiff's further care as follows:

> Rectal Adenocarcinoma -- s/p chemoradiation
> - help coordinate surgical appt with HUP as pt has been risk-stratified and would benefit from surgery occuring close to the time of chemoradiation
>
> Patient has completed his radiation therapy and chemotherapy. He is waiting for an approval to see the surgeon at the University of Pennsylvania. To this date he has not been scheduled for his operation.

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See page 1058 of the Philadelphia VA Medical Center's Progress Notes. A true and correct copy of the complete entry for the subject date, pages 1054-1059, is attached hereto as Exhibit "G".

33. On July 8, 2011, Douglas Jay Levine, an employee and agent of the Philadelphia VA Medical Center and Defendant, United States, noted in Plaintiff's record:

> Rectal CA: I have been in touch with the staff from medical oncology and surgical oncology. This patient **urgently needs surgical resection** as he has completed neoadjuvant chemoradiation. Per the chart, his 7078 form to approve payment of HUP for this procedure has been approved, but the most recent note from BRYANT,RODINA regarding that states: "The 7078 has not returned to me as of today (7/1/11) Sandra Hayes alerted. Patient can not be scheduled till 7078 returns to me via supervisor with proper authorization." We would prefer to deal with this issue while the patient remains an inpatient.
>
> Patient has completed his radiation therapy and chemotherapy. He is waiting for an approval to see the surgeon at the University of Pennsylvania. To this date he has not been scheduled for his operation.

See page 1032 (emphasis added) of the Philadelphia VA Medical Center's Progress Notes. A true and correct copy of the complete entry for the subject date, pages 1029-1032, is attached hereto as Exhibit "H".

34. On July 11, 2011, medical student Sunny J. Haft noted in the Plaintiff's records:

> # Rectal Adenocarcinoma
> - helping to coordinate surgical appt at HUP. Called the coordinator at Surg/Onc clinic and she informed me that they are still waiting on the 7078 form from the VA Chief of Staff that apporves payment to HUP for surgery.

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> Patient has completed his radiation therapy and chemotherapy. He is waiting for an approval to see the surgeon at the University of Pennsylvania. To this date he has not been scheduled for his operation.

See page 996 of the Philadelphia VA Medical Center's Progress Notes. A true and correct copy of the complete entry for the subject date, pages 995-997, is attached hereto as Exhibit "I".

35. On July 21, 2011, Plaintiff was seen again by Dr. Keerthi Gogineni, an employee and agent of the Philadelphia VA Medical Center and Defendant, United States, who expressly reported a breach in the standard of care in the Defendant's treatment of Plaintiff:

> -The length of time that elapsed since submission of 7078 form and granting of appointment at HUP is **unacceptable**. Will direct complaint towards administration. **Standard of care is that resection take place 5-10 weeks after completion of definitive chemoradiotherapy**. Forms were submitted in due time by surgical oncology here but it appears the delay occured during point in process where a "number" needed to be granted to confirm payment from the VA system to HUP. Thankfully the inpatient team identified the delay was due to this and pushed for a date.

See page 974 (emphasis added) of the Philadelphia VA Medical Center's Progress Notes. A true and correct copy of the complete entry for the subject date, pages 967-975, is attached hereto as Exhibit "J".

36. The Philadelphia VA Medical Center apparently was intending for Plaintiff to have treatment at a non-VA facility, Hospital of the University of Pennsylvania

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("HUP"), and the procedure for same was that the Defendant would submit a "7078 form" and confirm that HUP would be reimbursed for the cost of treatment.

37. Despite the identification of a breach in the standard of care and a bureaucratic delay in scheduling Plaintiff's care, the Philadelphia VA Medical Center continued to ignore Plaintiff's urgent medical needs.

38. On August 25, 2011, Dr. Keerthi Gogineni reported another visit with Mr. Delgado, detailed the Defendant's ongoing denial of medical care, and noted Plaintiff's fear and frustration caused by the Philadelphia VA Medical Center's conduct:

> Today:
> He saw Dr. Mahmoud on 8/15.
> Unfortunately, no medical records were provided to Dr. Mahmoud's office prior to this visit. He was told that records were necessary prior to further planning.
> No follow-up appointment was set.
> He was very upset; tearful after this. Felt like he wanted to drink/get high; frustrated after waiting so long for this evaluation. He did manage to get a cell phone from CSW.(215)XXX-XXXX(redacted)
> He is to see Sandra Hayes and surgical oncology today.
> Feels tired, dizzy. Hg low again. He admits to seeing dark stool. No frank blood. Has seen this over last 10 days. He feels diffuse pain. Says he ran out of Oxycodone because I provided less at last visit with instructions to titrate down; no clear source for pain.

See pages 951-952 of the Philadelphia VA Medical Center's Progress Notes. A true and correct copy of the complete entry for the subject date, pages 950-957, is attached hereto as Exhibit "K".

39. In this note, Dr. Keerthi Gogineni again reports a breach in the standard of care:

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> -Unfortunately, no records were provided to HUP to help inform his surgical planning and as far as I can tell, still no OR date 5 months out from completion of neoadjuvant chemorads. **Standard of care is that resection take place 5-10 weeks after completion of definitive chemoradiotherapy**. Forms were submitted in due time by surgical oncology here but it appears the delay occured during point in process where a "number" needed to be granted to confirm payment from the VA system to HUP.

See pages 956-957 of the Philadelphia VA Medical Center's Progress Notes at Exhibit "K".

40. Plaintiff was seen by Sandra L. Hayes, CRNP on August 30, 2011. Surgery was finally scheduled for September 9, 2011 to be performed at the Philadelphia VA Medical Center by Emily Paulson, M.D., an employee and agent of the Philadelphia VA Medical Center and Defendant, United States, rather than at HUP.

41. Plaintiff was admitted to the Philadelphia VA Medical Center for the planned surgery on September 7, 2011. He had been scheduled to undergo a fourth PET scan on September 8, 2011 and the EUS procedure and transanal excision of the residual rectal tumor on September 9, 2011. On September 8, 2011, Dr. Paulson noted that, due to a miscommunication with the PET team, Plaintiff could not get the PET/CT scan on that date.

42. On September 9, 2011, Dr. Paulson was to perform an Exam Under Anesthesia (EUA) and then a transanal resection of the residual polypoid tissue that was seen on the flexible sigmoidoscopy on June 9, 2011.

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See page 1793 of the Philadelphia VA Medical Center's Progress Notes. A true and correct copy of the complete entry for the subject date, pages 1792-1796, is attached hereto as Exhibit "L".

43. However, according to the records, Dr. Paulson was unable to locate the area in question during the EUA procedure and the resection was therefore unable to complete the resection.

See page 897 of the Philadelphia VA Medical Center's Progress Notes. A true and correct copy of the complete entry for the subject date, pages 896-897, is attached hereto as Exhibit "M".

44. Plaintiff, still hospitalized, underwent a fourth PET-CT scan on September 12, 2011. This scan revealed that Mr. Delgado's cancer had metastasized to his liver.

45. Plaintiff remained hospitalized and underwent a flexible sigmoidoscopy procedure on September 13, 2011 performed by Dr. John Lieb, M.D. Dr. Lieb was able to locate the residual tissue seen during the June 9, 2011 procedure and reported his findings as follows:

> Impression:
> 1.Some residual tissue present, likely just adenoma, likely unchanged from June. Removed with cold forceps and fulgurated with APC.
> 2.Adjacent scar site seen. Biopsied and also fulgurated. Tattooed just distal to this area

See page 861 of the Philadelphia VA Medical Center's Progress Notes. A true and correct copy of the complete entry for the subject date, pages 860-861, is attached hereto as Exhibit "N".

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46. In late 2011, Mr. Delgado underwent further chemotherapy which resulted in debilitating side effects.

47. In early 2012, Mr. Delgado underwent a surgery to remove the left lobe of his liver due to the metastasis of the rectal cancer to his liver

48. Plaintiff continues to this date and will continue in the future to undergo procedures, tests, and other medical treatment related to his cancer

49. Despite knowledge of the breach in the standard of care as documented in Defendant's own records, Defendant did not advise Plaintiff of the breach until May 20, 2014. On May 20, 2014, Plaintiff was requested to attend a meeting with Ralph M. Schapira, M.D., Chief of Staff, for the "Disclosure of an Adverse Event." Defendant's records indicate that Mr. Delgado was advised of the following information:

> Summary of information presented regarding adverse event: A delay in diagnosis of colon cancer which might have resulted in progression to a later stage

See page 610 of the Philadelphia VA Medical Center's Progress Notes. A true and correct copy of the complete entry for the subject date, pages 610-611, is attached hereto as Exhibit "O".

50. There was a delay of nearly one year between Plaintiff's diagnosis in December 2010 and the surgery in September 2011.

51. The injuries and losses suffered by the Plaintiff are the direct and proximate result of the negligence and carelessness of the United States and its employees and agents, acting individually or in concert, and are not due to any act or failure to act on the part of Plaintiff.

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52. The negligence and carelessness of the United States and its employees and agents was a substantial factor in bringing about Plaintiff's injuries and losses and a factual cause of Plaintiff's injuries and losses.

53. As a direct and proximate result of the negligence and carelessness of Defendant United States and its employees and agents, acting individually or in concert, Mr. Delgado has suffered and will continue to suffer forever severe personal injuries and losses including but not limited to the following:

a. progression of cancer;

b. spread of cancer;

c. need to undergo multiple diagnostic evaluations;

d. need to undergo procedures, tests, studies, therapies, treatments, and surgeries directed to his injuries, which would have been unnecessary in the absence of Defendant's negligence;

e. side effects of procedures, tests, studies, treatments, and surgeries which would have been unnecessary in the absence of Defendant's negligence;

f. side effects of procedures, tests, studies, treatments, and surgeries which would have been unnecessary in the absence of Defendant's negligence

g. increased risk of cancer, recurring cancer, and death from cancer;

h. mental anguish;

i. anxiety;

j. depression;

k. disfigurement;

l. humiliation and embarrassment;

m. mental and physical pain and suffering;

n. loss of enjoyment of life;

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o. loss of the chance for cure of his disease.

54. As a direct and proximate result of the negligence and carelessness of all named Defendants, acting individually or in concert, Mr. Delgado has also incurred medical and other healthcare expenses and an inability to engage in his usual household, occupational, and social activities.

COUNT I
PLAINTIFF V. UNITED STATES OF AMERICA

55. Plaintiff incorporates by reference Paragraphs 1 through 54 of this Complaint.

56. The Defendant United States knew or should have known that the Plaintiff's cancer required immediate treatment to prevent it from progressing and spreading. Accordingly, the Defendant is responsible for the claims made in this lawsuit

57. The Defendant United States knew or should have known that a delay of nearly one year between the Plaintiff's diagnosis and his surgery would allow his cancer to progress and spread. Accordingly, the Defendant is responsible for the claims made in this lawsuit.

58. The Defendant United States knew or should have known that the resection surgery should be performed 5 to 10 weeks after Mr. Delgado completed chemoradiotherapy, yet failed to schedule and perform the surgery. Accordingly, the Defendant is responsible for the claims made in this lawsuit.

59. The United States knew or should have known that Plaintiff was in need of close follow-up and urgent treatment for his liver, yet failed to closely monitor and urgently treat Mr. Delgado's medical condition. Accordingly, the Defendant is responsible for the claims made in this lawsuit.

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60. The United States knew or should have known that a delay in the treatment provided to Plaintiff would allow the cancer to progress and/or spread to other areas of Plaintiff's body, yet allowed delays in his care to occur. Accordingly, the Defendant is responsible for the claims made in this lawsuit.

61. The United States knew or should have known of the substantial risk for Mr. Delgado's cancer to progress and spread and yet failed to closely monitor and treat him. Accordingly, the Defendant is responsible for the claims made in this lawsuit.

62. The United States knew or should have known that Plaintiff would be subject to a substantial risk of serious harm if he was not closely monitored and treated, yet failed to closely monitor and treat him. Accordingly, the Defendant is responsible for the claims made in this lawsuit.

63. The United States knew or should have known that the resection surgery should have been and was not performed within 5 to 10 weeks after Mr. Delgado completed chemoradiotherapy, yet failed to warm him of the same. Accordingly, the Defendant is responsible for the claims made in this lawsuit.

64. The negligence and carelessness of the Defendant, United States, acting directly and through its agents (actual ostensible or otherwise) servants and/or employees included the following:

a. Vicarious liability for the negligence acts of its agents, servants and/or employees including all medical providers identified in this Complaint;

b. Failure to schedule and complete surgery for nearly a year after Plaintiff's diagnosis;

c. Failure to properly treat Plaintiff's cancer which was diagnosed in December 2010;

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d. Failure to perform necessary procedures within 5 to 10 weeks after the completion of chemoradiotherapy;

e. Failure to adequately assess Mr. Delgado to plan his course of treatment;

f. Failure to monitor Mr. Delgado's medical condition;

g. Failure to timely and properly treat Mr. Delgado's medical condition;

h. Failure to ensure that unnecessary and inappropriate delays did not occur to inhibit Mr. Delgado's access to medical treatment;

i. Failure to ensure that unnecessary and inappropriate delays did not allow Mr. Delgado's cancer to progress and spread;

j. Failure to ensure that unnecessary and inappropriate delays did not cause Mr. Delgado to have to undergo additional PET scans, diagnostic procedures, and diagnostic tests or studies;

k. Failure to exercise due care in the professional practice of several medical disciplines;

l. Failure to advise Plaintiff of the Defendant's negligence;

m. Failure to properly and adequately treat and care for Mr. Delgado;

n. For other negligent acts of commission and omission that caused the catastrophic injuries to Mr. Delgado.

65. The negligence of the Defendant, as described herein, was the legal cause of the Plaintiff's injuries and damages as described herein

66. The negligence of the Defendant, as described herein, increased the risk of harm to Plaintiff who suffered the injuries and damages as detailed in the within Complaint.

67. As a direct and proximate result of the negligence and carelessness of the Defendant, and as described herein, the Plaintiff suffered and the Defendant is liable to the Plaintiff for the described injuries and damages

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68. As a direct and proximate result of the negligence and/or carelessness of the Defendant as described herein, Mr. Delgado suffered the following injuries and damages

a. Progression of cancer;

b. Spread of cancer;

c. Need to undergo multiple diagnostic evaluations;

d. Need to undergo procedures, tests, studies, therapies, treatments, and surgeries directed to his injuries, which would have been unnecessary in the absence of Defendant's negligence;

e. Side effects of procedures, tests, studies, treatments, and surgeries which would have been unnecessary in the absence of Defendant's negligence;

f. Increased risk of cancer, recurring cancer, and death from cancer;

g. Mental anguish;

h. Anxiety;

i. Depression;

j. Disfigurement;

k. Humiliation and embarrassment;

l. Mental and physical pain and suffering;

m. Loss of enjoyment of life;

o. Loss of the chance for cure of his disease.

69. As a result of the aforesaid injuries caused by Defendant, Plaintiff sustained the following injuries and damages:

a. Expenses in connection with the providing of medical and surgical attention, hospitalization, medical supplies, surgical appliances, medicines and attending services;

b. Impairment to Plaintiff's general health, strength and vitality;

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c. Permanent damage to organs;

d. Chronic pain and/or discomfort;

e. Other severe and serious injuries and losses.

WHEREFORE, Plaintiff, Raul Delgado, demands judgment against Defendant, The United States of America, exclusive of costs and such other remedies as this Honorable Court deems just and proper.

COUNT II
PLAINTIFF V. THE UNITED STATES OF AMERICA

70. Plaintiff incorporates by reference Paragraphs 1 through 69 of this Complaint.

71. The Defendant United States knew or should have known that the Plaintiff's cancer required immediate treatment to prevent it from progressing and spreading. The Defendant United States knew or should have known that a delay of nearly one year between the Plaintiff's diagnosis and his surgery would allow his cancer to progress and spread. The Defendant United States knew or should have known that the resection surgery should be performed 5 to 10 weeks after Mr. Delgado completed chemoradiotherapy, yet failed to schedule and perform the surgery. The United States knew or should have known that Plaintiff was in need of close follow-up and urgent treatment for his liver, yet failed to closely monitor and urgently treat Mr. Delgado's medical condition. The United States knew or should have known that a delay in the treatment provided to Plaintiff would allow the cancer to progress and/or spread to other areas of Plaintiff's body, yet allowed delays in his care to occur. The United States knew or should have known of the substantial risk for Mr. Delgado's cancer to progress

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and spread and yet failed to closely monitor and treat him. Accordingly, the Defendant is responsible for the claims made in this lawsuit

72. The negligence and carelessness of the Defendant, United States, acting directly included the following:

a. Failure to develop, administer, implement policies and procedures to ensure timely treatment of patients, including Mr. Delgado, who urgently need treatment;

b. Failure to train employees to ensure timely treatment of patients, including Mr. Delgado, who urgently need treatment;

c. Failure to develop, administer, implement policies and procedures for proper communication among medical providers;

d. Failure to develop, administer, implement policies and procedures to ensure proper communication within the hospital systems concerning the status of patient care and treatment;

e. Failure to provide proper oversight to the healthcare team to ensure that Mr. Delgado would receive timely monitoring and treatment to treat Mr. Delgado's medical condition and prevent its progression and spread;

f. Failure to properly select competent, trained and supervised health care providers who are capable of meeting the requisite standard(s) of care and to ensure proper consult and avoidance of delays in treatment;

g. Failure to develop, administer, implement a training program and/or train hospital personnel on the avoidance of delays in the treatment of patients.

73. The negligence of the Defendant, as described herein, was a legal cause of the Plaintiff's injuries and damages as described herein.

74. The negligence of the Defendant, as described herein, increased the risk of harm to Mr. Delgado who suffered the injuries and damages as detailed in the within Complaint.

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75. As a direct and proximate result of the negligence and carelessness of the Defendant, and as described herein, the Plaintiff suffered and the Defendant is liable to the Plaintiff for the within described injuries and damages.

76. As a direct and proximate result of the negligence and/or carelessness of the Defendant as described herein, Mr. Delgado suffered the following injuries and damages:

a. Progression of cancer;

b. Spread of cancer;

c. Need to undergo multiple diagnostic evaluations;

d. Need to undergo procedures, tests, studies, therapies, treatments, and surgeries directed to his injuries, which would have been unnecessary in the absence of Defendant's negligence;

e. Side effects of procedures, tests, studies, treatments, and surgeries which would have been unnecessary in the absence of Defendant's negligence;

f. Increased risk of cancer, recurring cancer, and death from cancer;

g. Mental anguish;

h. Anxiety;

i. Depression;

j. Disfigurement;

k. Humiliation and embarrassment;

l. Mental and physical pain and suffering;

m. Loss of enjoyment of life;

o. Loss of the chance for cure of his disease.

77. As a result of the aforesaid injuries caused by Defendant, Plaintiff sustained the following injuries and damages:

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a. Expenses in connection with the providing of medical and surgical attention, hospitalization, medical supplies, surgical appliances, medicines and attending services;

b. Impairment to Plaintiff's general health, strength and vitality;

c. Permanent damage to organs;

d. Chronic pain and/or discomfort;

e. Other severe and serious injuries and losses.

WHEREFORE, Plaintiff, Raul Delgado, demands judgment against Defendant, The United States of America, exclusive of costs and such other remedies as this Honorable Court deems just and proper.

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NOTICE OF PRESERVATION OF EVIDENCE

PLAINTIFFS HEREBY DEMAND AND REQUEST THAT DEFENDANT TAKE NECESSARY ACTION TO ENSURE THE PRESERVATION OF ALL DOCUMENTS, COMMUNICATIONS, WHETHER ELECTRONIC OR OTHERWISE, ITEMS AND THINGS IN THE POSSESSION OR CONTROL OF ANY PARTY TO THIS ACTION, OR ANY ENTITY OVER WHICH ANY PARTY TO THIS ACTION HAS CONTROL, OR FROM WHOM ANY PARTY TO THIS ACTION HAS ACCESS TO, ANY DOCUMENTS, ITEMS, OR THINGS WHICH MAY IN ANY MANNER BE RELEVANT TO OR RELATE TO THE SUBJECT MATTER OF THE CAUSES OF ACTION AND/OR THE ALLEGATIONS OF THIS COMPLAINT.

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DEMAND FOR JURY TRIAL

Pursuant to Rule 38 of the Federal Rules of Civil Procedure, Plaintiffs demand a trial by jury on all issues.

THE BEASLEY FIRM, LLC

Date: 4/12/16

By: _____

DANA H. AUGUSTINE, ESQUIRE
PA Attorney I.D. No. 81276
The Beasley Firm, LLC
1125 Walnut Street
Philadelphia, Pennsylvania 19107
215.592.1000
215.592.8360 (telefax)
dana.augustine@beasleyfirm.com
Attorney for Plaintiff

CERTIFICATE OF SERVICE

I, Dana H. Augustine, Esquire, certify that a true and correct copy of the foregoing Civil Action Complaint was served via first class mail on April 12, 2016 upon the following:

James C. Sinwell, Esquire
U.S. Department of Veterans Affairs
Office of General Counsel
North Atlantic District – North
VA Pittsburgh Healthcare System
1010 Delafield Road
Pittsburgh, PA 15215

THE BEASLEY FIRM, LLC

Date: 4/12/16

By: _____
DANA H. AUGUSTINE, ESQUIRE

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EXHIBIT A

CLAIM FOR DAMAGE, INJURY, OR DEATH

INSTRUCTIONS: Please read carefully the instructions on the reverse side and supply information requested on both sides of this form. Use additional sheet(s) if necessary. See reverse side for additional instructions.

FORM APPROVED
OMB NO. 1105-0008

1. Submit to Appropriate Federal Agency:

VA REGIONAL COUNSEL (642-02)
3900 Woodland Avenue
Philadelphia, PA 19104

2. Name, address of claimant, and claimant's personal representative if any. (See instructions on reverse). Number, Street, City, State and Zip code.

Raul Jesus Delgado
6617 Charles St.-Apt. 27
Philadelphia, PA 19135

Maxwell S. Kennerly, Esq.
The Beasley Firm, LLC
1125 Walnut Street
Philadelphia, PA 19107

3. TYPE OF EMPLOYMENT	4. DATE OF BIRTH	5. MARITAL STATUS	6. DATE AND DAY OF ACCIDENT	7. TIME (A.M. OR P.M.)
☒ MILITARY ☐ CIVILIAN	04/23/1946	Single	02/01/2011 09/2011	

8. BASIS OF CLAIM (State in detail the known facts and circumstances attending the damage, injury, or death, identifying persons and property involved, the place of occurrence and the cause thereof. Use additional pages if necessary).

Claimant Raul Jesus Delgado is a veteran and long-standing patient of the VA. It was recently disclosed to him that, while being treated for rectal adenocarcinoma in 2011, the VA breached the standard of care by failing to schedule him for resection 5 to 10 weeks after completion of definitive chemoradiotherapy, causing a delay of several months in his cancer treatment.

9. PROPERTY DAMAGE

NAME AND ADDRESS OF OWNER, IF OTHER THAN CLAIMANT (Number, Street, City, State, and Zip Code).

None

BRIEFLY DESCRIBE THE PROPERTY, NATURE AND EXTENT OF THE DAMAGE AND THE LOCATION OF WHERE THE PROPERTY MAY BE INSPECTED. (See instructions on reverse side).

10. PERSONAL INJURY/WRONGFUL DEATH

STATE THE NATURE AND EXTENT OF EACH INJURY OR CAUSE OF DEATH, WHICH FORMS THE BASIS OF THE CLAIM. IF OTHER THAN CLAIMANT, STATE THE NAME OF THE INJURED PERSON OR DECEDENT.

Delayed treatment of recognized rectal adenocarcinoma, and with it increased complications and severity and spread of the cancer.

11. WITNESSES

NAME	ADDRESS (Number, Street, City, State, and Zip Code)
Medical Professionals at the VA	

12. (See instructions on reverse). AMOUNT OF CLAIM (in dollars)

12a. PROPERTY DAMAGE	12b. PERSONAL INJURY	12c. WRONGFUL DEATH	12d. TOTAL (Failure to specify may cause forfeiture of your rights).
0.00	$500,000		0.00 $500,000

I CERTIFY THAT THE AMOUNT OF CLAIM COVERS ONLY DAMAGES AND INJURIES CAUSED BY THE INCIDENT ABOVE AND AGREE TO ACCEPT SAID AMOUNT IN FULL SATISFACTION AND FINAL SETTLEMENT OF THIS CLAIM.

13a. SIGNATURE OF CLAIMANT (See instructions on reverse side).	13b. PHONE NUMBER OF PERSON SIGNING FORM	14. DATE OF SIGNATURE
Raul Jesus Delgado	215-4[illegible]-2056	JUL-11-2014

CIVIL PENALTY FOR PRESENTING FRAUDULENT CLAIM

The claimant is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages sustained by the Government. (See 31 U.S.C. 3729).

CRIMINAL PENALTY FOR PRESENTING FRAUDULENT CLAIM OR MAKING FALSE STATEMENTS

Fine, imprisonment, or both. (See 18 U.S.C. 287, 1001.)

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NSN 7540-00-634-4046

STANDARD FORM 95 (REV. 2/2007)
PRESCRIBED BY DEPT. OF JUSTICE
28 CFR 14.2

INSURANCE COVERAGE

In order that subrogation claims may be adjudicated, it is essential that the claimant provide the following information regarding the insurance coverage of the vehicle or property.

15. Do you carry accident insurance? ☐ Yes If yes, give name and address of insurance company (Number, Street, City, State, and Zip Code) and policy number. ☐ No

None

16. Have you filed a claim with your insurance carrier in this instance, and if so, is it full coverage or deductible? ☐ Yes ☐ No

None

17. If deductible, state amount.

0.00 NONE

18. If a claim has been filed with your carrier, what action has your insurer taken or proposed to take with reference to your claim? (It is necessary that you ascertain these facts).

None

19. Do you carry public liability and property damage insurance? ☐ Yes If yes, give name and address of insurance carrier (Number, Street, City, State, and Zip Code). ☐ No

None

INSTRUCTIONS

Claims presented under the Federal Tort Claims Act should be submitted directly to the "appropriate Federal agency" whose employee(s) was involved in the incident. If the incident involves more than one claimant, each claimant should submit a separate claim form.

Complete all items - insert the word NONE where applicable.

A CLAIM SHALL BE DEEMED TO HAVE BEEN PRESENTED WHEN A FEDERAL AGENCY RECEIVES FROM A CLAIMANT, HIS DULY AUTHORIZED AGENT, OR LEGAL REPRESENTATIVE, AN EXECUTED STANDARD FORM 95 OR OTHER WRITTEN NOTIFICATION OF AN INCIDENT, ACCOMPANIED BY A CLAIM FOR MONEY DAMAGES IN A SUM CERTAIN FOR INJURY TO OR LOSS OF PROPERTY, PERSONAL INJURY, OR DEATH ALLEGED TO HAVE OCCURRED BY REASON OF THE INCIDENT. THE CLAIM MUST BE PRESENTED TO THE APPROPRIATE FEDERAL AGENCY WITHIN TWO YEARS AFTER THE CLAIM ACCRUES.

Failure to completely execute this form or to supply the requested material within two years from the date the claim accrued may render your claim invalid. A claim is deemed presented when it is received by the appropriate agency, not when it is mailed.

If instruction is needed in completing this form, the agency listed in item #1 on the reverse side may be contacted. Complete regulations pertaining to claims asserted under the Federal Tort Claims Act can be found in Title 28, Code of Federal Regulations, Part 14. Many agencies have published supplementing regulations. If more than one agency is involved, please state each agency.

The claim may be filed by a duly authorized agent or other legal representative, provided evidence satisfactory to the Government is submitted with the claim establishing express authority to act for the claimant. A claim presented by an agent or legal representative must be presented in the name of the claimant. If the claim is signed by the agent or legal representative, it must show the title or legal capacity of the person signing and be accompanied by evidence of his/her authority to present a claim on behalf of the claimant as agent, executor, administrator, parent, guardian or other representative.

If claimant intends to file for both personal injury and property damage, the amount for each must be shown in item number 12 of this form.

The amount claimed should be substantiated by competent evidence as follows:

(a) In support of the claim for personal injury or death, the claimant should submit a written report by the attending physician, showing the nature and extent of the injury, the nature and extent of treatment, the degree of permanent disability, if any, the prognosis, and the period of hospitalization, or incapacitation, attaching itemized bills for medical, hospital, or burial expenses actually incurred.

(b) In support of claims for damage to property, which has been or can be economically repaired, the claimant should submit at least two itemized signed statements or estimates by reliable, disinterested concerns, or, if payment has been made, the itemized signed receipts evidencing payment.

(c) In support of claims for damage to property which is not economically repairable, or if the property is lost or destroyed, the claimant should submit statements as to the original cost of the property, the date of purchase, and the value of the property, both before and after the accident. Such statements should be by disinterested competent persons, preferably reputable dealers or officials familiar with the type of property damaged, or by two or more competitive bidders, and should be certified as being just and correct.

(d) **Failure to specify a sum certain will render your claim invalid and may result in forfeiture of your rights.**

PRIVACY ACT NOTICE

This Notice is provided in accordance with the Privacy Act, 5 U.S.C. 552a(e)(3), and concerns the information requested in the letter to which this Notice is attached.

A. *Authority:* The requested information is solicited pursuant to one or more of the following: 5 U.S.C. 301, 28 U.S.C. 501 et seq., 28 U.S.C. 2671 et seq., 28 C.F.R. Part 14.

B. *Principal Purpose:* The information requested is to be used in evaluating claims.

C. *Routine Use:* See the Notices of Systems of Records for the agency to whom you are submitting this form for this information.

D. *Effect of Failure to Respond:* Disclosure is voluntary. However, failure to supply the requested information or to execute the form may render your claim "invalid."

PAPERWORK REDUCTION ACT NOTICE

This notice is solely for the purpose of the Paperwork Reduction Act, 44 U.S.C. 3501. Public reporting burden for this collection of information is estimated to average 6 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Director, Torts Branch, Attention: Paperwork Reduction Staff, Civil Division, U.S. Department of Justice, Washington, DC 20530 or to the Office of Management and Budget. Do not mail completed form(s) to these addresses.

EXHIBIT B

U.S. Department of Veterans Affairs
Office of Regional Counsel
Region 4

Janeecia Bing, Paralegal Specialist
Direct Dial (215) 823-5800, Ext. 7692

VA Medical Center
3900 Woodland Avenue
Philadelphia, PA 19104
(215) 823-7811 Fax No.: (215) 823-7821

July 22, 2014

In reply refer to:
RC 4 Case No.: 7394

Maxwell S. Kennerly, Esquire
The Beasley Firm, LLC
1125 Walnut Street
Philadelphia, PA 19107

SUBJ: *DELGADO, Raul Jesus (last 4 SS – 8155)*
Administrative Tort Claim

Dear Attorney Kennerly:

This is to acknowledge receipt of the Standard Form 95, Claim for Damage, Injury, or Death, filed by you on July 11, 2014 on behalf of your client, Raul J. Delgado and received in our offices on July 18, 2014. In order for us to further investigate and adjudicate this administrative tort claim, we request that you forward the following information to support the claims of negligence, injury and damages. (See 28 Code of Federal Regulations § 14.4)

(1) a written report by the attending physician setting forth the nature and extent of treatment, any degree of temporary or permanent disability, the prognosis, period of hospitalization, and any diminished earning capacity;

(2) itemized bills for medical and hospital expenses incurred, or itemized receipts of payments for such expenses;

(3) if the prognosis reveals the need for future treatment, a statement of expected expenses for such treatment;

(4) a copy of the expert medical opinion you are relying on to support the allegations of negligence and damages in this case;

(5) copies of all medical records for treatment received by non-VA hospitals and physicians from PERIOD OF ONE YEAR PRIOR TO INCIDENT CONTINUING TO THE PRESENT DATE;

(6) if a claim is made for loss of time from employment, a written statement from Mr. Delgado's employer showing actual time lost from employment, whether he was a full-time or part-time employee, and wages or salary actually lost;

(7) if a claim is made for loss of income and Mr. Delgado was self-employed, documentary evidence showing the amount of earnings actually lost;

(8) any other evidence or information which may have a bearing on either the responsibility of the United States for the injury or the damages claimed.

Please provide us with a copy of the fee agreement between you and Mr. Delgado.

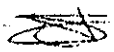
Upon receipt of all of the information and evidence outlined above, this office will conduct an investigation of the circumstances that gave rise to your claim and you will be advised of our decision at the earliest opportunity. Please note that pursuant to the Federal Tort Claims Act (FTCA)*, a Federal Agency has six months from the date this claim was received in which to investigate a tort claim, (July 18, 2014). The case has been assigned to Staff Attorney, Stephen Pahides.

If you have any further questions regarding this matter, you may write to the above address or call Staff Attorney Stephen Pahides at 215-823-5800 ext 7679. Thank you for your cooperation.

Sincerely,

STEPHEN PAHIDES
Staff Attorney

By:



JANEECIA BING
Paralegal Specialist

FTCA claims are governed by a combination of Federal and State laws. Some state laws may limit or bar a claim or law suit. VA attorneys handling FTCA claims work for the Federal government, and cannot provide advice regarding the impact of state laws or state filing requirements.

EXHIBIT C

U.S. Department of Veterans Affairs
Office of General Counsel
North Atlantic District - North

James C. Sinwell, Esq.
Deputy Chief Counsel
Direct Dial (412) 822-1584

VA Pittsburgh Healthcare System
1010 Delafield Road
Pittsburgh, PA 15215

October 23, 2015

Dana Augustine, Esquire
The Beasley Firm, LLC
1125 Walnut Street
Philadelphia, PA 19107

In Reply Refer To: *SC4-7394*

SUBJ: **Delgado, Raul Jesus**
Administrative Tort Claim

Dear Ms. Augustine:

We have concluded our investigation of the administrative tort claim your firm filed on behalf of Raul Delgado alleging that he was the victim of medical malpractice during the diagnosis and treatment of his rectal cancer at the Philadelphia VAMC. Our investigation into this matter has concluded, and our investigation of the circumstances surrounding this claim did not reveal evidence of any negligent or wrongful act or omission of any employee of the federal government acting within the scope of his office or employment. Our investigation found that that the standard of care was followed by Mr. Delgado's clinicians at the Philadelphia VAMC in providing for his care and treatment.

If you are dissatisfied with this decision, you may file a request for reconsideration of your claim by any of the following means: (1) mail to Office of General Counsel (021B), 810 Vermont Avenue, N.W., Washington, DC 20420; (2) fax to 202-273-6385; or (3) e-mail to OGC.torts@mail.va.gov. To be timely filed, VA must receive this request prior to the expiration of 6 months from the date of the mailing of this final denial. Upon filing such a request for reconsideration, VA shall have 6 months from the date of that filing in which to make final disposition of the claim, and your option to file suit in an appropriate U.S. District Court under 28 U.S.C. 2675(a) shall not accrue until 6 months after the filing of such request for reconsideration (28 C.F.R. Section 14.9).

In the alternative, if you are dissatisfied with the action taken on your claim, you may file suit in accordance with the Federal Tort Claims Act, sections 1346(b) and 2671-2680, title 28, United States Code, which provides that a tort claim that is administratively denied may be presented to a Federal district court for judicial consideration. Such a suit must be initiated within 6 months after the date of the mailing of this notice of final denial as shown by the date of this letter

(section 2401(b), title 28, United States Code). If you do initiate such a suit, you are further advised that the proper party defendant is the United States, not VA.

Please note that FTCA claims are governed by a combination of Federal and State laws. Some state laws may limit or bar a claim or law suit. VA attorneys handling FTCA claims work for the Federal government, and cannot provide advice regarding the impact of state laws or state filing requirements.

If you decide to initiate a suit against the Department of Veterans Affairs, you are advised that the proper defendant is the United States of America (28 U.S.C. §1346(b) and §2671, et. seq.) Should you have any questions for our office, please contact Sara Aull at (412) 822-1581.

Sincerely,

JAMES C. SINWELL
Deputy Chief Counsel

EXHIBIT D

Progress Notes

tumor is left after the treatments you have gotten, which will assist those providers in caring for you. Since you do not have a phone I am notifying you with this letter. We are suggesting a 2 day preparation which was ordered for you as well. Please let us know if you have questions or concerns. The main GI number is 215 823 5800 ext 5122. Scheduling is extension 6437. We are now located on the 4th floor (we have moved).

Sincerely,

John G. Lieb II MD

/es/ John G Lieb II M.D.
GASTROENTEROLOGY ATTENDING
Signed: 05/25/2011 17:32

05/25/2011 ADDENDUM STATUS: COMPLETED
Of course the date and time were added to the letter before mailing.

/es/ John G Lieb II M.D.
GASTROENTEROLOGY ATTENDING
Signed: 05/25/2011 17:43

06/01/2011 ADDENDUM STATUS: COMPLETED
Pt states he needs anesthesia for colonoscopy and an inpt 2 day prep. This will take a good bit of time to set up and therefore could delay his surgery. He has no escort. Instead what I suggest is just the EUS with a one day prep. He stopped by just now and we discussed these issues in detail. I asked him to take 3/4 of the go lytely the day before and a one day clear liquid diet. Most people who get rectal EUS can tolerate it without any sedation at all. He is amenable to this plan.

/es/ John G Lieb II M.D.
GASTROENTEROLOGY ATTENDING
Signed: 06/01/2011 08:57

LOCAL TITLE: SURGICAL ONCOLOGY FOLLOW-UP
STANDARD TITLE: HEMATOLOGY AND ONCOLOGY OUTPATIENT NOTE
DATE OF NOTE: MAY 24, 2011@18:01 ENTRY DATE: MAY 24, 2011@18:01:33
AUTHOR: HAYES,SANDRA L CRNP EXP COSIGNER:
URGENCY: STATUS: COMPLETED

*** SURGICAL ONCOLOGY FOLLOW-UP Has ADDENDA ***

Clinic Date:5/24/11

Progress Notes

DELGADO,RAUL JESUS 281-42-8155

Summary:
64yro/M for f/u s/p neoadjuv.CTX/XRT for rectal ca.
Briefly,pt.h/o recttal mass on 2007 c-scope incompletely excised with pathology c/w rectal adenoma.The patient missed several GI/EUS appointments @ HUP in 2007. He was lost to follow-up until recent hospital admission in 2/2010 @ outside Medical Ctr.for MI s/p 4V CABG,now on plavix/asa who reportedly underwent c-scope & informed he should return to VA for further management of rectal mass. The patient underwent 12/9/2010 c-scope @ PVAMC revealling
He is s/p c-scope to ascending colon 12/9/10 revealling 5cm rectal mass 7cm from anal verge;poor prep w/inability to evaluate for other polyps or masses.
Since lesion was thought to be most c/w a large adenoma,GI recommended EMR & EUS therefore pt.had c-scope to cecum w/EMR 12/20/10 was significant for a large recto-sigmoid junction polyp w/flat component,~80% removed w/path c/w adenoCA.
A 12/23/11 staging PET/CT confirmed rectal lesion & suggest cecum/ascending colon incr.uptake w/SUV 5 c/w inflamm.vs mets.
Dr.Leib,GI Attending did not recommend EUS due to questionable accuracy in staging the tumor".. given the large bulk of the polyp which can give false impression of invasion with any pressure against it and it would have been almost impossible to get completely around the base of it to assess for invasion. For those reasons I elected not to EUS it preprocedure.
That being said I am willing to proceed with repeat colonoscopy/EUS in one month or so, if essential from a surgical perspective..."

The pt.is now s/p neoadjuv.CTX/XRT completing 5040cGY 2/14-4/7/11.Preop CEA=1.2.
He is s/p post-treatment re-staging revealling:
-5/11/11 PET/CT/Impression:
1. A new focal uptake in the left liver is suspicious for metastasis. Close follow up is recommended.
2. Interval further decreased FDG uptake in the left side wall of the rectosigmoid region, indicating significant metabolic response to recent therapy.
3. Multiple inguinal nodes with mild FDG uptake, essentially not changed from prior study.

-5/11/11 abd/pelv.CT w/o contr./Impression:
No clear evidence of local spread of the patient's known rectal cancer or of metastasis with very mild fat stranding about the rectum, likely on the basis of radiation.
Anemia.
Likely small bilateral nonobstructive kidney stones.
Note: This examination is limited without IV contrast.

5/11/11 chest CT w/o contr./Impression:
No clear evidence of metastatic spread of rectal cancer to the patient's chest.

Progress Notes

Comment:
CT of the chest is compared to a PET scan the same day.
The lungs are clear. The heart is normal in size.
The thyroid gland and esophagus are normal in appearance.
Heart muscles well visualized and is noncontrast CT scan in keeping with anemia.
Multiple surgical clips are visualized in the mediastinum in this patient is status post CABG. A right-sided chemotherapy port is present.

5/12/11 abd.U/S:
Comparison: CT scan of 05/11/2011
Comments: Ultrasound images of the abdomen were performed.

The liver measures 13.3 cm length which is not enlarged. There is increased hepatic echogenicity in keeping with nonspecific hepatocellular disease.No gross space occupying intrahepatic lesions are identified.
The spleen measures 10 cm in length which is not enlarged.
Limited Doppler images show normal directional blood flow in the portal vein. Portal vein measures 0.6 cm in diameter which is within normal limits.The pancreas is incompletely visualized.
The right kidney measures 10.5 cm in length. There is no right hydronephrosis. The left kidney measures 10.4 cm in length.
There is no left hydronephrosis. There are bilateral renal calcifications.
The gallbladder appears unremarkable. No gallstones or pericholecystic fluid is identified.. The extrahepatic bile duct measures 0.2 cm in diameter, which is within normal limits. There is no intrahepatic biliary ductal dilatation.
Impression:
Bilateral renal calcifications. No hydronephrosis.

IMPRESSION:64yro/M rectal adenoCA.s/p neoadjuv.CTX/XRT 5040cGY 2/14-4/7/11.
Pre-treatment PET/CT did not show liver lesion,however most recent 5/11/11 PET s/f interval development of L.lobe liver lesion,SUV 4;no other liver masses.
Post-treatment C/A/P CT w/o contr.(crt.=3);no e/o mets.dz.;& abd.U/S not c/w liver mass.
Of note,pre-treatment since pt.w/h/o unresected rectal adenoma since 2007, GI recommended c-scope/EMR for dx./treatment of this lesion;however EMR was unsuccessful in completed rxn.of the lesion & final path showed adenoCA.
Pt.did not have EUS per GI/Dr.Leib:"...due to questionable accuracy in staging the tumor".. given the large bulk of the polyp which can give false impression of invasion with any pressure against it and it would have been almost impossible to get completely around the base of it to assess for invasion. For those reasons I elected not to EUS it preprocedure.
That being said I am willing to proceed with repeat colonoscopy/EUS in one month or so, if essential from a surgical perspective..."

Progress Notes

PLAN:
-Consult GI for EUS >depth of invasion is needed to plan surgergical approach.
-Non VA Fee Basis consult for Colorectal Surgery Evaluation
-Will present case @ Tumor Board for consensus on management of liver lesion.
Pt.d/w & seen w/Dr.Schnelldorfer,GI Surgery Attending.

Care Options:
Since it is unclear if lesion completely resected therefore the concensus of the Board,that is Physcian Representatives from Surgery,Medical Oncology, Radiation Oncology,Pathology & Radiology is to offer standard treatment for rectal malignancy which is neoadjuvant CTX/XRT & post-treatment re-staging with PET/CT. If post-treatment PET/CT c/w abnormality in cecum,then would recommend repeat colonoscopy prior to proceeding with any further treatment.

/es/ SANDRA L. HAYES
NP
Signed: 01/19/2011 10:42

Receipt Acknowledged By:
01/21/2011 16:51 /es/ THOMAS SCHNELLDORFER
GI ATTENDING SURGEON

/es/ SANDRA L. HAYES
NP
Signed: 05/24/2011 18:45

Receipt Acknowledged By:
05/25/2011 09:08 /es/ THOMAS SCHNELLDORFER
GI ATTENDING SURGEON

05/24/2011 ADDENDUM STATUS: COMPLETED
Please ignore the below section of the 5/24/11 note:

"Care Options:
Since it is unclear if lesion completely resected therefore the concensus of the Board,that is Physcian Representatives from Surgery,Medical Oncology, Radiation Oncology,Pathology & Radiology is to offer standard treatment for rectal malignancy which is neoadjuvant CTX/XRT & post-treatment re-staging with PET/CT. If post-treatment PET/CT c/w abnormality in cecum,then would recommend repeat colonoscopy prior to proceeding with any further treatment.

/es/ SANDRA L. HAYES
NP
Signed: 01/19/2011 10:42

EXHIBIT E

Progress Notes

*****ScaUNote]

*****ScaUNote]
Click on Tools, click on Imaging,you may be required to log into Vista with your Access/Verify codes. Now click on the Image you wish to view.

*** SCANNED DOCUMENT ***
SIGNATURE NOT REQUIRED

Electronically Filed: 06/27/2011
by: TARYN KIMBERLEY MANN

LOCAL TITLE: GI FLEX SIG CONSULT*
STANDARD TITLE: GASTROENTEROLOGY PROCEDURE CONSULT
DATE OF NOTE: JUN 09, 2011@12:53 ENTRY DATE: JUN 09, 2011@12:53:36
AUTHOR: LIEB,JOHN G EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Patient Name & SSN: DELGADO,RAUL JESUS 281-42-8155
Indication:visualize tumor site endoscopically post neoadj chemorads.
Physician performing the procedure:John Lieb II MD
Location of procedure: GI Endoscopic Unit
Medication:
No medication was used.
Procedure:
After 3/4 go lytely, the scope was inserted without difficulty.
The scope was advanced to the sigmoid at 40cm with a mininal air insufflation.
The examination was completed.
The patient tolerated the procedure well.
The prep quality was fair.

The details of the findings were as follows:
Rectum: Mild internal hemorroids.
Again as seen during colonoscopy, just proximal to the second valve of Houston at about 6-7cm from the anal verge. I saw the EMR scar which looked healthy. There was some residual 8mm by 8 mm or so of what looked to be sessile

adenoma. There was also some hyperplasia in the area, likely radiation effects.
I elected not to biopsy because I do not think that would affect decision-making regarding surgery.
Sigmoid colon: What was seen up to 40cm was normal.

Impression:
Scar seen in rectum as above with likely small amount of residual adenomatous appearing tissue.
Recommendations:
Follow up with medical oncology and surgery service.

/es/ John G Lieb II M.D.
GASTROENTEROLOGY ATTENDING
Signed: 06/09/2011 13:00

LOCAL TITLE: GI EUS/ERCP
STANDARD TITLE: GASTROENTEROLOGY CONSULT
DATE OF NOTE: JUN 09, 2011@12:44 ENTRY DATE: JUN 09, 2011@12:44:53
AUTHOR: LIEB,JOHN G EXP COSIGNER:
URGENCY: STATUS: COMPLETED

*** GI EUS/ERCP Has ADDENDA ***

*****Radiographic Image attached to this note******
Click on Tools, click on Imaging,you may be required to log into Vista with your Access/Verify codes. Now click on the Image you wish to view.

Rectal EUS

Indication: restaging of rectal CA after neoadjuvant chemorads

Physician: John Lieb II MD
Nurse: Steven Tranchitella RN
Tech: Kia Neely

Procedure: After informed consent and a time out, the radial olympus EUS scope was inserted through the anus and advanced to about 30cm where the iliac vessels were seen.

There was no adenopathy around the area of past lesion/scar or around the iliac vessels.

The prostate was enlarged with calcifications but a clear border was seen between it and the rectum and also between the seminal vesciles and the rectum.

EXHIBIT F

Progress Notes

Medication times: Yes
Armband: Yes
Priviledges: Yes
Contraband rules: Yes
Patient understands he/she must notify primary nurse prior to leaving the unit:Yes

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VALUABLES:
Cash: $none
Disposition of valuables: Sent Home
Describe valuables patient kept:
Patient clothing bagged with patient identifier attached:Yes
Clothing sent:

ADL ABILITIES:
Eating: Self
Toileting: Self
Bathing: Self
Grooming: Self
Dressing: Self
Mobility: walks without assistance
Transferring: Self
Turning: Self

PATIENT RIGHTS/RESPONSIBILITIES:
Reviewed patient rights and responsibilities with patient and patient does verbalize understanding.

SIDE RAILS:
Discussed the use of side rails with patient and patient is able to make informed decision concerning the use of side rails:Yes, patient wants side rails up for mobility/security/comfort

/es/ MICHAEL LITTLEJOHN
HEALTH TECHNICIAN
Signed: 07/07/2011 18:19

LOCAL TITLE: ER ATTENDING NOTE
STANDARD TITLE: ATTENDING EMERGENCY DEPARTMENT NOTE
DATE OF NOTE: JUL 07, 2011@10:22 ENTRY DATE: JUL 07, 2011@10:22:17
AUTHOR: NEJMAN,GRACE EXP COSIGNER:

Progress Notes

URGENCY: STATUS: COMPLETED

*** ER ATTENDING NOTE Has ADDENDA ***

ER Triage Note reviewed
HPI:DELGADO,RAUL JESUS is a 65 y/o MALE with a pmh significant for rectal adenocarcinoma, CAD, CABG referred from hematology oncology clinic because of abnormal laboratory test results on 6/30/11. Patient states that he has had increasing fatigue and shortness of breath with exertion. He denies any chest pain. He denies any abdominal pain, melena, hematocrit TZ. Patient has been eating well. Denies any weight loss. He denies any fever or cough. He has been taking his medications.

Patient has completed his radiation therapy and chemotherapy. He is waiting for an approval to see the surgeon at the University of Pennsylvania. To this date he has not been scheduled for his operation.

Allergies/ADR: Patient has answered NKA

Medications reviewed with patient: Has taken morning doses of medications

2)	AMLODIPINE BESYLATE 10MG TAB TAKE ONE TABLET BY MOUTH ONCE DAILY (NOTE THE DOSAGE/STRENGTH)HIGHER DOSE	ACTIVE
3)	ASPIRIN 81MG CHEW TAB CHEW ONE TABLET BY MOUTH EVERY DAY	ACTIVE
4)	ATENOLOL 25MG TABLET TAKE ONE TABLET BY MOUTH TWICE A DAY	ACTIVE
6)	LISINOPRIL 10MG TAB TAKE ONE TABLET BY MOUTH ONCE DAILY FOR BLOOD PRESSURE	ACTIVE
7)	OXYCODONE HCL/ACETAMINOPHEN 5/325 TAB TAKE 1 TABLET BY MOUTH EVERY 6 HOURS	ACTIVE
8)	ROSUVASTATIN CA 40MG TAB TAKE ONE-HALF TABLET BY MOUTH ONCE DAILY FOR CHOLESTEROL IN PLACE OF SIMVASTATIN.	ACTIVE

PMH:
Rectal adenocarcinoma
Chronic kidney disease
Venous insufficiency
CAD status post MI, CABG 2010 N. STEMI 3/2010. Plavix and aspirin discontinued
Hyperlipidemia
Diabetes mellitus
Vision impairment one I
Anemia acquired

Vital signs reviewed:
BP: 122/49 (07/07/2011 09:14)
Temp:97.1 F [36.2 C] (07/07/2011 09:14)
HR: 55 (07/07/2011 09:14)

Progress Notes

Resp: 16 (07/07/2011 09:14)
Pulse Ox: 7/7/11 @ 0914 PULSE OXIMETRY: 100
pAIN: 7 (07/07/2011 09:14)

PHYSICAL EXAM
General: pleasant NAD
Mental status:Alert and oriented x3
Skin: warm and dry pale
HEENT: Normocephalic. oral mucosa moist neck supple
CV: HRR w/o Murmur , ectopy, rub
Pulm: Respirations easy Lungs CTA No rales rhonchi or wheeze
GI: abdomen scaphoid soft NT BS active no guarding or rebound
Extrem: No edema

DATA ANALYSIS
ECG: Sinus bradycardia otherwise unchanged compared to 4/25/11
Laboratory:

BLOOD	07/07 2011 09:58	06/30 2011 13:53	06/16 2011 09:56	05/12 2011 10:05	04/14 2011 09:36	Units	Reference Ranges
WBC	7.7	5.8	8.9	8.9	8.0	THOU/CUMM	4.8 - 10.8
RBC	2.35 L	2.12 L	2.69 L	2.41 L	2.68 L	MIL/CUMM	4.2 - 6.1
HGB	7.6 L	6.8 L*	8.8 L	7.8 L	8.8 L	g/dL	12 - 18
HCT	22.5 L	19.8 L	24.8 L	22.6 L	24.9 L	%	37 - 51
MCV	95.4	93.4	92.1	93.7	92.8	fL	81 - 99
MCH	32.3 H	32.3 H	32.9 H	32.2 H	32.8 H	PG	27 - 31
MCHC	33.8	34.6	35.7	34.4	35.4	G/dL	33.0 - 38.0
RDW	13.5	13.6	13.6	16.8 H	17.2 H	%	11.5 - 14.5
PLT	114 L	117 L	116 L	188	193	THOU/CUMM	130 - 400

SERUM	07/07 2011 09:58	06/30 2011 13:53	05/12 2011 10:05	04/06 2011 11:50	04/06 2011 11:49	Units	Reference Ranges
GLUCOSE	187 H	160 H	171 H	274 H	269 H	mg/dL	71 - 99
NA	139	137	141	144	142	mmol/L	136 - 144
K+	5.0	5.9 H	5.7 H	4.4	4.4	mmol/L	3.6 - 5.1
CL	115 H	111	110	113 H	113 H	mmol/L	101 - 111
C02	17 L	20 L	25	24	24	mmol/L	22 - 32
BUN	82 H	78 H	51 H	40 H	41 H	mg/dL	8 - 20
CREAT	3.82 H	3.58 H	3.04 H	2.36 H	2.33 H	mg/dL	0.70 - 1.20
CA	8.8 L	8.4 L	8.8 L	8.4 L	8.3 L	mg/dL	8.9 - 10.3

Radiology:
Prior records reviewed: YES

TREATMENT IN ED:

Progress Notes

Hep-Lock, type and screen

IMPRESSION:
Symptomatic anemia- patient agreeable to transfusion
Rectal adenocarcinoma- surgical care needs to be coordinated with University of Pennsylvania
Chronic renal disease
Diabetes mellitus controlled

/es/ Dr. Grace Nejman
Director, Emergency Department
Signed: 07/07/2011 13:31

07/07/2011 ADDENDUM STATUS: COMPLETED
Patient admitted to medicine
Handoff communication to Dr. Levin Condition: stable
Code status: Full
Critical care time: None

/es/ Dr. Grace Nejman
Director, Emergency Department
Signed: 07/07/2011 17:05

LOCAL TITLE: ER TRIAGE/NURSING NOTE*
STANDARD TITLE: EMERGENCY DEPT TRIAGE NOTE
DATE OF NOTE: JUL 07, 2011@09:15 ENTRY DATE: JUL 07, 2011@09:15:09
AUTHOR: MCCREA,AMY L EXP COSIGNER:
URGENCY: STATUS: COMPLETED

*** ER TRIAGE/NURSING NOTE* Has ADDENDA ***

Mode of Arrival:	Public Transportation
Homeless:	No.
Level of Consciousness: A x O x3	Yes
High risk Situation:	No.
Severe pain or distress :	No Pain Index(0-10) 0

PATIENT AGE:	65
GENDER:	MALE
HEART RATE:	55 (07/07/2011 09:14)
RESPIRATIONS:	16 (07/07/2011 09:14)
Pulse Ox:	7/7/11 @ 0914 PULSE OXIMETRY: 100
Temperature:	97.1 F [36.2 C] (07/07/2011 09:14)
Blood Pressure:	122/49 (07/07/2011 09:14)
Weight:	129 lb [58.6 kg] (06/16/2011 10:59)
Fingerstick Glucose:	

EXHIBIT G

Progress Notes

Signed: 07/08/2011 11:01

LOCAL TITLE: MEDICINE RESIDENT ADMIT HISTORY & PHYSICAL
STANDARD TITLE: INTERNAL MEDICINE RESIDENT ADMISSION EVALUATION
DATE OF NOTE: JUL 07, 2011@19:25 ENTRY DATE: JUL 07, 2011@19:25:59
AUTHOR: HAFT,SUNNY J EXP COSIGNER:
URGENCY: STATUS: COMPLETED

PATIENT NAME: DELGADO,RAUL JESUS 281-42-8155

CC: "they sent me a letter, I need a transfusion"

HPI:

Pt is a 65 yo male with a PMH of rectal adenocarcinoma and adjuvant chemorad completed on 4/7/11, CAD, s/p CABG, CKD, and type II Diabetes who p/w a complaint of
needing a transfusion due to low Hgb levels found 1 week ago in the heme/onc clinic. Patient has needed regular transfusions since completing his chemorad therapy and reports that the transfusions have made him feel "stronger." The pt had routine labs checked 6/30/2011 which showed worsening anemia, hyperkalemia, and acute on chronic kidney injury. The hemeonc clinic was unable to contact him via the phone, so they sent him a letter asking him to present for blood transfusion.The pt presented to the ED and was admitted to the inpatient floor.

Pt also complains of fatigue and being "generally tired and weak" since 7 days ago. Fatigue is worse when walking, and has been getting progressively worse over the last couple days. However, his fatigue is not enough to interfere with daily functioning and was only brought up as a secondary/minor complaint. He denies SOB and syncope. Also denies fevers, chills, cough. He denies chest pain. He acknowledges "being more cold than usual" over the last week as well.

Pt also complains of "losing my sight when I stand" since 7 days ago. He reports that his vision blacks out briefly upon standing and returns within a few seconds. He reports that he has been eating and drinking well recently, and denies any weight gain or loss.

Primary Care Provider: MARSHALL,KATHLEEN E

Outpatient Primary Care provider: OGOREK,CARRIE P

Allergies: NKDA

Other Allergies: Patient has answered NKA

Medications:

Progress Notes

OUTPT MEDICATIONS:

DRUG	STATUS
ACCU-CHEK COMFORT CV(GLUCOSE) TEST STRIP	ACTIVE
SIG: USE 1 STRIP FOR TESTING TWICE A WEEK	
AMLODIPINE BESYLATE 10MG TAB	ACTIVE
SIG: TAKE ONE TABLET BY MOUTH ONCE DAILY (NOTE THE DOSAGE/STRENGTH)HIGHER DOSE	
DERMA CERIN TOP CREAM	ACTIVE
SIG: APPLY SMALL AMOUNT TO AFFECTED AREA DAILY	
TRIAMCINOLONE ACETONIDE 0.1% CREAM	ACTIVE
SIG: APPLY SMALL AMOUNT TO AFFECTED AREA TWICE A DAY	
UREA 20% CREAM	ACTIVE
SIG: APPLY MODERATE AMOUNT TO AFFECTED AREA TWICE A DAY ONLY TO RIGHT LEG WHERE THERE IS SCALE	
LISINOPRIL 10MG TAB	ACTIVE
SIG: TAKE ONE TABLET BY MOUTH ONCE DAILY FOR BLOOD PRESSURE	
ATENOLOL 25MG TABLET	ACTIVE
SIG: TAKE ONE TABLET BY MOUTH TWICE A DAY	
ROSUVASTATIN CA 40MG TAB	ACTIVE
SIG: TAKE ONE-HALF TABLET BY MOUTH ONCE DAILY FOR CHOLESTEROL IN PLACE OF SIMVASTATIN.	
OXYCODONE HCL/ACETAMINOPHEN 5/325 TAB	ACTIVE
SIG: TAKE 1 TABLET BY MOUTH EVERY 6 HOURS	

INPT MEDICATIONS:

DRUG	DOSE	STATUS	SIG
OXYCODONE/APAP 5/325 UD (TABLE	1	ACTIVE	
SIG: EVERY 6 HOURS AS NEEDED			
AMLODIPINE BESYLATE 10MG TAB	1	ACTIVE	QDAY
ATENOLOL 25MG TABLET	1	ACTIVE	EVERY 12 HOURS
INSULIN REG HUMAN 100 UNIT/ML	1	ACTIVE	QAC&HS (INSULIN)
ROSUVASTATIN CA 20MG TAB	1	ACTIVE	QHS
TRIAMCINOLONE ACETONIDE 0.1% C	1	ACTIVE	TWICE DAILY
CARBAMIDE 20% CREAM UD	1	ACTIVE	TWICE DAILY
ACETAMINOPHEN 325MG TABLET UD	2	ACTIVE	ONCE

Past Medical History:
1. Rectal adenonocarcinoma dx 12/9/10, completed neoadjuvant chemorads on 4/7/11
2. Chronic Kidney Disease
3. CAD s/p 4 vein CABG in 2010 following an MI, aspirin and Plavix discontinued
4. Type II Diabetes

Progress Notes

5. HTN
6. Venous Stasis Dermatitis following saphenous vein harvest for CABG
7. Anemia acquired

Past Surgical History: CABG 3/2010

Surgical Procedures (as listed in VISTA):
SURGERIES - NONE FOUND

Social History:
Marital Status: NEVER MARRIED
Lives with: alone
Employment: NOT EMPLOYED
ETOH: denies
Smoke: denies
Drug use: denies

Family History: Patient is not survived by any family and is unaware of any significant medical hx in his family

ROS:
no HA
no CP
no SOB
no N/V/D
no BRBPR
no Abd pain
no Urinary complaints
no rashes

Physical Exam:

Vital Signs:	HR 60 BP 122/49 RR 16 Temp 97.1 O2 Sat 100 RA
General:	well-groomed male in no apparent distress, is ambulatory with no difficulty
HEENT:	sclera anicteric, EOMI, mouth: moist mucous membranes, no lesions
Neck:	No JVD, no bruits no adenopathy, no thyroid enlargement or masses

Progress Notes

Chest: Clear to auscultation, chemo port palpable on R upper chest, mediastinal scar from prior surgery

Card: RRR, no murmurs or gallops appreciated, strong radial pulses

Abd: Soft, NT, normal bowel sounds, no organomegaly

Extr: large purple lichenified plaques covering lower extremities, no cyanosis or edema

Neuro: Strength 5/5 throughout
Normal gait

Labs: 7/7/11 in ED

WBC	7.7	
RBC	2.35	L
HGB	7.6	L
HCT	22.5	L
MCV	95.4	
MCH	32.3	H
MCHC	33.8	
RDW	13.5	
PLT	114	L
MPV	9.1	
NEUT%	70.2	H
LYMPH%	8.9	L
MONO%	8.1	
EOS%	11.8	H
BASO%	1.0	
NEUT #	5.4	
LYMPH #	0.7	L
MONO #	0.6	
EOS #	0.9	H
BASO #	0.1	H
GLUCOSE	187	H
NA	139	
K+	5.0	
CL	115	H
C02	17	L
BUN	82	H
CREAT	3.82	H
CA	8.8	L
MG	1.7	L

Progress Notes

EGFR 17

ALT:	18 IU/L	(07/07/2011 09:58)
Alkph:	62 IU/L	(07/07/2011 09:58)
AST:	18 IU/L	(07/07/2011 09:58)
Bili:	0.6 mg/dL	(07/07/2011 09:58)
T.Chol:	94 mg/dL L	(02/10/2011 10:47)
Alb:	4.0 g/dL	(07/07/2011 09:58)
T.Prot:	7.0 g/dL	(07/07/2011 09:58)
LDH:	0	

Assessment:

Pt is a 65 yo male with a PMH of rectal adenocarcinoma and adjuvant chemorad completed 3 months ago, CAD, CABG, CKD, and type II Diabetes who p/w a complaint of needing a transfusion following his outpatient hemeonc appointment 7 days ago. Pt also complains of general weakness over the last 1 week, likely due to a combination of his anemia and metabolic acidosis as seen on labs. Physical exam was unremarkable besides lower extremity venous stasis dermatitis.
Pt also needs a surgical appt at HUP for tumor removal.

Plan:

1. Fatigue -- likely due to a combination of his anemia and metabolic acidosis secondary to a combination of radiation tx and acute on chronic kidney injury:
- PRBC transfusion

2. Anemia -- chemo/radiation bone marrow suppression vs occult blood loss from rectal tumor vs decreased EPO production from worsening kidney injury:
- PRBC transfusion
- recheck CBC in am
- holding EPO as patient is undergoing potentially curative cancer tx and EPO may in fact stimulate tumor growth

3. Acute on chronic kidney disease -- due to possible compression of ureter by tumor vs Lisinpril use vs anemia vs dehydration
- d/c Lisinopril
- U/S of kidneys to look for hydronephrosis
- IV fluids plus PRBC transfusion

4. Rectal Adenocarcinoma -- s/p chemoradiation
- help coordinate surgical appt with HUP as pt has been risk-stratified and would benefit from surgery occuring close to the time of chemoradiation

Progress Notes

5. Venous Stasis Dermatitis
- continue use of pressure stockings
- continue using creams

6. HTN
- cont Atenolol and amlodopine
- hold lisinopril

7. CAD
- cont atenolol and crestor, pt has been off of Plavix and aspirin

8. DM
- cont monitoring glucose levels as they have been high recently
- encourage healthy eating for glucose control

9. FEN
- diabetic diet

10. Prophylaxis
- give subq heparin

11. Dispo
- return home when medically stable

/es/ SUNNY J HAFT
medical student
Signed: 07/08/2011 08:38

LOCAL TITLE: NURSING ADMISSION ASSESSMENT-PART 1
STANDARD TITLE: NURSING ADMISSION EVALUATION NOTE
DATE OF NOTE: JUL 07, 2011@18:12 ENTRY DATE: JUL 07, 2011@18:12:15
AUTHOR: LITTLEJOHN,MICHAEL EXP COSIGNER:
URGENCY: STATUS: COMPLETED

NURSING ADMISSION ASSESSMENT - PART I

(To be completed by RN, LPN or Health Tech)

Date and time of arrival: Mode of Arrival: wheelchair

Admit to: 5EMED Admit from:

VA Armband placed using active identification by patient stating

EXHIBIT H

Progress Notes

Printed On Jun 05, 2013

DATE OF NOTE: JUL 08, 2011@09:09 ENTRY DATE: JUL 08, 2011@09:09:25
AUTHOR: HAFT,SUNNY J EXP COSIGNER:
URGENCY: STATUS: COMPLETED

*** MEDICAL STUDENT DAILY PROGRESS NOTE Has ADDENDA ***

Name: DELGADO,RAUL JESUS SSN: 281-42-8155

Subjective:

Pt states he feels much better this morning following his PRBC transfusions last night. Denies any fatigue this morning and has no other complaints at this time.

Objective:
Vitals:
BP: 145/59 (07/08/2011 08:50)
P: 55 (07/08/2011 08:50)
TEM: 97.9 F [36.6 C] (07/08/2011 08:50)
R: 18 (07/08/2011 08:50)
O2 Sat: 100
General: well appearing, ambulatory
Head & Neck: moist mucous membranes, sclera anicteric
Chest: clear bilaterally
Heart: RRR, nl S1 and S2
Abdomen: soft, nontender
GI: no blood per rectum
Ext: purple lichenified plaques on lower extremities, not bleeding, no edema

Labs:
WBC: 7.1 THOU/CUMM (07/08/2011 06:00)
HgB: 9.8 g/dL L (07/08/2011 06:00)
PLT: 112 THOU/CUMM L (07/08/2011 06:00)
CHEM 7:

Inpatient Meds:
INPT MEDICATIONS:

DRUG	DOSE	STATUS	SIG
OXYCODONE/APAP 5/325 UD (TABLE	1	ACTIVE	
SIG: EVERY 6 HOURS AS NEEDED			
AMLODIPINE BESYLATE 10MG TAB	1	ACTIVE	QDAY
ATENOLOL 25MG TABLET	1	ACTIVE	EVERY 12 HOURS
INSULIN REG HUMAN 100 UNIT/ML	1	ACTIVE	QAC&HS (INSULIN)
ROSUVASTATIN CA 20MG TAB	1	ACTIVE	QHS
TRIAMCINOLONE ACETONIDE 0.1% C	1	ACTIVE	TWICE DAILY

Progress Notes

CARBAMIDE 20% CREAM UD	1	ACTIVE	TWICE DAILY
HEPARIN NA 5000 UNITS SYR	1	ACTIVE	EVERY 8 HOURS

Assessment:

Pt is a 65 yo male with a h/o rectal adenocarcinoma and neoadjuvant chemorad therapy 3 completed 3 months ago, CKD, CAD, s/p CABG 1.5 yrs ago, and diabetes who p/w mild fatigue in the setting of anemia, low HCO3, hyperkalemia, and a decreased GFR from baseline. Pt presenting with an acute on chronic worsening of kidney disease. Big obstacle to pt care is communication and sw is working on getting him a cell phone.

Plan:

Fatigue:
- completed 2 units of PRBC transfusion last night

Anemia
- s/p PRBC transfusion
- awaiting morning labs to monitor change in hgb
- holding EPO as pt has cancer and there are concerns for tumor growth

Acute on Chronic Kidney Disease
- renal U/S scheduled for today to look for hydronephrosis
- pt given IV fluids
- d/ced Lisinopril due to lowering of GFR from baseline. Lisinopril is not cleared well by the kidney and there is increase in bioavailability once GFR drops below 30

Rectal Adenocarcinoma
- helping to coordinate surgical appt at HUP
- call oncologist to confirm appropriateness of surgery at this time?

HTN
- cont atenolol and amlodipine
- hold lisinopril

CAD
- cont statin with amlodipine
- consider starting on ASA again

DM
- consider starting on insulin and/or Glipizide as glucose is not well controlled

FEN - diabetic diet

Prophylaxis

Progress Notes

- give subq heparin

Dispo
- currently medically stable, may go home today if U/S is nl
- should not go home until sw finds pt a cell phone as he needs a good way for hemeonc and surgery to contact him

/es/ SUNNY J HAFT
medical student
Signed: 07/08/2011 10:43

07/08/2011 ADDENDUM STATUS: COMPLETED
Patient examined and case discussed with HS.

BP:145/59 (07/08/2011 08:50)
P: 55 (07/08/2011 08:50)
T: 97.9 F [36.6 C] (07/08/2011 08:50)
RR:18 (07/08/2011 08:50).

65 yo male with h/o CAD s/p CABG, CRI, DM and rectal adeno CA s/p CTX/XRT awaiting resection admitted for Hg 6.8, K 5.9, Cr 3.8 (from 2-3) on labs while in heme/onc clinic. ECG without changes. Patient is currently s/p 2U PRBC and IVF. This AM Hg 9.8 , K 4.8, Cr 3.34. Patient is donig well this AM without complaints, lungs clear, RRR, abd soft NT/ND, no LE edema. Would continue to hold ACE given problems with hyperkalemia, renal u/s to r/o obstruction in setting of rectal ca. Currently on SS insulin for known DM; was not taking meds as outpatient will need to be d/c on new outpatient regimen. See HS note for additional issues; agree with assessment and plan as detailed above.

/es/ Virginia Chang, MD
MD
Signed: 07/08/2011 11:02

07/08/2011 ADDENDUM STATUS: COMPLETED
Agree with medical student progress note

S: pt feels much improved after the blood transfusion. He denies any complaints today except for chronic pain at his port site

O: VSS. lungs CTAB. Abd soft, ntnd

A/P:
Anemia: now improved s/p transfusion. Likely will be an ongoing issue given rectal CA, CKD, and recent chemorads

Progress Notes

AoCKD: FeNa not consistent with dehydration. Somewhat improved with hydration.
- check renal U/S
- hold lisinopril

Rectal CA: I have been in touch with the staff from medical oncology and surgical oncology. This patient urgently needs surgical resection as he has completed neoadjuvant chemoradiation. Per the chart, his 7078 form to approve payment of HUP for this procedure has been approved, but the most recent note from BRYANT,RODINA regarding that states:

"The 7078 has not returned to me as of today (7/1/11) Sandra Hayes alerted. Patient can not be scheduled till 7078 returns to me via supervisor with proper authorization."

We would prefer to deal with this issue while the patient remains an inpatient.

Pain control: continue percocet

/es/ DOUGLAS JAY LEVINE
Resident
Signed: 07/08/2011 11:50

LOCAL TITLE: SOCIAL WORK NOTE
STANDARD TITLE: SOCIAL WORK NOTE
DATE OF NOTE: JUL 08, 2011@08:38 ENTRY DATE: JUL 08, 2011@08:38:05
AUTHOR: GALLAGHER,DONALD EXP COSIGNER:
URGENCY: STATUS: COMPLETED

This case manager visited Vet in his hospital room to obtain updates regarding his recent admission.

Vet stated he was feeling ill the past week or so and decided to visit the PVAMC ED. Vet was screened and admitted for further observation.

Vet was in good spirits and stated he may be leaving this afternoon.

Vet was instructed to visit this case manager before he left to assist him in obtaining a free cell phone through either Assurance or SafeLink.
Vet admitted it is difficult for his providers to reach him to discuss his medical treatment. Vet stated he only receives paper mail from providers.

Vet stated his apartment is going well, he was able to pay his July rent.
Vet stated his AC works well which has been helpful during the past week of excessive heat.

EXHIBIT I

Progress Notes

URGENCY: STATUS: COMPLETED

*** MEDICAL STUDENT DAILY PROGRESS NOTE Has ADDENDA ***

Name: DELGADO,RAUL JESUS SSN: 281-42-8155

Subjective:
Pt has no complaints o/n. Pt inquiring into when he can go home, and was informed that he will be seen for a renal U/S this morning and that he needs a surgery appt at HUP as well for cancer resection.

Pt reports good urine output and fluid intake. Denies dry mouth or signs of orthostatic hypotension. Reports he no longer feels fatigued following his transfusion 3 days ago.

Objective:
Vitals:
BP: 129/64 (07/11/2011 03:06)
P: 93 (07/11/2011 03:06), measured at bedside: 72
TEM: 98.5 F [36.9 C] (07/11/2011 03:06)
R: 20 (07/11/2011 03:06)
O2 Sat: 96 RA
Head & Neck: moist mucous membranes
Chest: Lungs clear bilaterally
Heart: RRR, no murmurs or rubs appreciated
Abdomen: NABS
Ext: good cap refill (under 2 secs), no edema

Labs:
WBC: 7.2 THOU/CUMM (07/10/2011 06:00)
HgB: 9.9 g/dL L (07/10/2011 06:00)
PLT: 103 THOU/CUMM L (07/10/2011 06:00)
CHEM 7:

Inpatient Meds:
INPT MEDICATIONS:

DRUG	DOSE	STATUS	SIG
AMLODIPINE BESYLATE 10MG TAB	1	ACTIVE	QDAY
ATENOLOL 25MG TABLET	1	ACTIVE	EVERY 12 HOURS
INSULIN REG HUMAN 100 UNIT/ML	1	ACTIVE	QAC&HS (INSULIN)
ROSUVASTATIN CA 20MG TAB	1	ACTIVE	QHS
TRIAMCINOLONE ACETONIDE 0.1% C	1	ACTIVE	TWICE DAILY
CARBAMIDE 20% CREAM UD	1	ACTIVE	TWICE DAILY
HEPARIN NA 5000 UNITS SYR	1	ACTIVE	EVERY 8 HOURS

Progress Notes

Assessment:

Pt is a 65 yo male with a h/o rectal adenocarcinoma and neoadjuvant chemorad therapy completed 3 months ago, CKD, CAD, s/p CABG 1.5 yrs ago, and diabetes who p/w mild fatigue in the setting of anemia, low HCO3, hyperkalemia, and a decreased GFR from baseline. Hgb improved s/p transfusion and pt feeling much better.Pt presenting with an acute on chronic worsening of kidney disease as well and will recieve a renal U/S today. Big obstacle to pt care is communication and sw is working on getting him a cell phone.

Plan:

Anemia
- s/p PRBC transfusion
- hgb 9.9 and stable as of yesterday
- holding EPO as pt has cancer and there are concerns for tumor growth

Acute on Chronic Kidney Disease
- renal U/S scheduled for today to look for hydronephrosis
- d/ced Lisinopril due to lowering of GFR from baseline. Lisinopril is not cleared well by the kidney and there is increase in bioavailability once GFR drops below 30 (GFR currently at 19)

Rectal Adenocarcinoma
- helping to coordinate surgical appt at HUP. Called the coordinator at Surg/Onc clinic and she informed me that they are still waiting on the 7078 form from the VA Chief of Staff that apporves payment to HUP for surgery.
- Called outpt heme/onc clinic, pt has appt on 7/14 at 8:15

HTN
- cont atenolol and amlodipine
- hold lisinopril

CAD
- cont statin with amlodipine
- consider starting on ASA again (oncologist recommends against this while pt is anemic per his most recent note)

DM
- pt currently on insulin as an inpt
- consider starting on home insulin and/or Glipizide as glucose is not well controlled

FEN - diabetic diet

Prophylaxis
- give subq heparin

Progress Notes


```
# Dispo
        - currently medically stable, may go home today if U/S is nl
        - ideally should not go home until sw finds pt a cell phone as he needs
a good way for hemeonc and surgery to contact him (currently can only be
contacted via postal mail)


/es/ SUNNY J HAFT
medical student
Signed: 07/11/2011 09:38

Receipt Acknowledged By:
07/13/2011 17:56        /es/ SARA M CORR
                             MD

07/11/2011 ADDENDUM                        STATUS: COMPLETED
I have sent a note to the Chief of Staff to check on the status of the 7078 form
for his surgical care.

/es/ DAVID A. ASCH
MD
Signed: 07/11/2011 11:05

07/11/2011 ADDENDUM                        STATUS: COMPLETED
Resident addendum:

Agree with excellent MS note.

S: No complaints, No O/N events.

O:Temp: 97.4 F [36.3 C] (07/11/2011 08:50)
BP: 134/63 (07/11/2011 08:50)
HR: 58 (07/11/2011 08:50)
RR: 20 (07/11/2011 08:50)
02 sat: 7/11/11 @ 0850      PULSE OXIMETRY: 100


Exam:
NAD, well appearing
RRR
CTAB
abd s, nt, nd
no edema


BLOOD      07/11      07/10      07/09      07/08      07/07           Reference
            2011       2011       2011       2011       2011
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EXHIBIT J

Progress Notes

STANDARD TITLE: SOCIAL WORK NOTE
DATE OF NOTE: JUL 21, 2011@12:05 ENTRY DATE: JUL 21, 2011@12:05:48
AUTHOR: GALLAGHER,DONALD EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Vet visited the HUD-VASH office to complete the application for a phone through Assurance Wireless.

The application was signed by Vet and an updated income statement was included.

The application packet was faxed to Assurance Wireless at 1-877-732-3018.

Vet was informed if he is approved and receives a phone in the mail he is to bring it in to the HUD-VASH office in order for me to help him activate the phone.

Vet reported he is doing well during this week of excessive heat, Vet stated his AC is functioning properly in his home.

/es/ Donald Gallagher, LSW
Social Worker
Signed: 07/21/2011 12:13

Receipt Acknowledged By:
08/22/2011 11:43 /es/ ANDREW P BRENZA
Social Worker

LOCAL TITLE: HEM/ONC ATTENDING PROGRESS NOTE
STANDARD TITLE: HEMATOLOGY AND ONCOLOGY ATTENDING NOTE
DATE OF NOTE: JUL 21, 2011@11:01 ENTRY DATE: JUL 21, 2011@11:01:28
AUTHOR: GOGINENI,KEERTHI EXP COSIGNER:
URGENCY: STATUS: COMPLETED

OUTPATIENT HEMATOLOGY-ONCOLOGY VISIT:7/21/11

LAST SEEN:6/16/11

DIAGNOSIS: Rectal adenocarcinoma

STAGE:TXNXM0

Progress Notes

No EUS performed due to ?distortion after EMR which unexpectedly demonstrated adenocarcinoma.

PRIOR TREATMENTS:
Status post neoadjuvant chemorads
Cycle 1 (2/14-2/18/11):5-FU 1000MG/M2=1660MG PER DAY FOR 5 DAYS
Cycle 2 (3/21-3/25/11): 5-FU 1000MG/M2=1660MG PER DAY FOR 5 DAYS (technically one week delay, i.e. day 34 instead of day 29 because of missed RT days)
Completed RT 4/7/11: 5040cGy

6/9/11 had EUS and flex sig procedure with Dr. Lieb:
EUS Impression:
1.Some thicking for about 10-15 cm in the rectal wall, starting about 3cm from anal verge involving layer 2. This is almost certainly post radiation changes. Musculars propria and deeper rectal layers intact and unaffected as above.
2.No visible local/regional adenopathy.

Flex sig
Impression:
Scar seen in rectum as above with likely small amount of residual adenomatous appearing tissue.
Recommendations:
Follow up with medical oncology and surgery service.

CURRENT TREATMENT: Awaiting surgery!

ECOG STATUS:0

HPI/INTERVAL HISTORY: Mr. Delgado is a 64 yo gentleman with history of coronary disease s/p 4V CABG in 3/2010 who was subsequently managed on ASA & Plavix who has a rectal adenocarcinoma. He had a colonoscopy in 2007 demonstrating rectal adenoma, and was lost to follow-up thereafter until he presented with syncope resulting in the cardiac evaluation/CABG in 3/2010. At that time, he reports having had a c-scope at Hahnemann. I have not seen this report. Coordination of his procedures and prep has been complicated by nonexistant social support, no phone, blood thinners, poor preps, etc. Ultimately re-evaluated at the VA in 12/9/2010, and c-scope then apparently showed a lesion 7cm from the anal verge that looked like a polypoid adenoma. Mass was not biopsied at that time as he was on ASA and Plavix, and plan was for follow-up EMR/EUS and biopsy as well as repeat evaluation of remaining colon given poor prep. He had a repeat C-scope on 12/20- he had ~80% of the lesion removed via EMR; EUS was not performed. Unexpectedly, biopsy of the mass showed a focus of adenocarcinoma arising from a TV adenoma. He had a PET-CT on 12/21 (one day after his procedure) showing SUV max 16.9 at the proximal rectum/distal sigmoid colon and soft tissue density measuring 41 x 29 mm in the cecum / proximal ascending colon with diffuse tracer uptake (max SUV of 5.0). Dr. Lieb in retrospect mentioned possible abrasion at the cecum due to

instrumentation corresponding to this uptake. Tumor board discussion (at which I was not present) culminated in decision to proceed with neoadjuvant therapy due to bulk of the lesion as visualized on c-scope as EUS at this time post EMR was felt to offer limited utility re depth of invasion of residual lesion and despite unknown extent/presence of nodal involvement.

Today:
He was hospitalized for 5 days last week.
Outpatient labs showed low Hg, admitted via ER for transfusion.
He denies having noted bleeding symptoms.

Supposed to get a cell phone through the VA to facilitate communication with outpatient docs; hasn't gotten it yet.

He was kept in house in part to nail down details re 7078 form; needs an OR date ASAP. Now has an appt with surg onc at HU for 8/15--- Dr. Mahmoud.
This is 4 months after completing neoadjuvant chemorads!

Stopped Lisinopril due to symptoms and K.

PMH:
CKD (baseline pretreatment was Cr 2.55)
DM
CAD (preserved EF)

ALL:NKDA

RX:
MEDICATIONS (as listed in Vista):
Active Outpatient Medications (excluding Supplies):

	Active Outpatient Medications	Status
1)	ACCU-CHEK COMFORT CV(GLUCOSE) TEST STRIP USE 1 STRIP FOR TESTING TWICE A WEEK	ACTIVE
2)	AMLODIPINE BESYLATE 10MG TAB TAKE ONE TABLET BY MOUTH ONCE DAILY (NOTE THE DOSAGE/STRENGTH)HIGHER DOSE	ACTIVE (S)
3)	ATENOLOL 25MG TABLET TAKE ONE TABLET BY MOUTH TWICE A DAY	ACTIVE (S)
4)	DERMA CERIN TOP CREAM APPLY SMALL AMOUNT TO AFFECTED AREA DAILY	ACTIVE
5)	ERGOCALCIFEROL (VIT D2) 50,000UNIT CAP TAKE ONE CAPSULE BY MOUTH WEEKLY FOR VITAMIN D REPLACEMENT	ACTIVE
6)	OXYCODONE HCL/ACETAMINOPHEN 5/325 TAB TAKE 1 TABLET BY MOUTH EVERY 6 HOURS AS NEEDED FOR PAIN.	ACTIVE
7)	ROSUVASTATIN CA 40MG TAB TAKE ONE-HALF TABLET BY MOUTH ONCE DAILY FOR CHOLESTEROL IN PLACE OF	ACTIVE (S)

Progress Notes

SIMVASTATIN.
8) TRIAMCINOLONE ACETONIDE 0.1% CREAM APPLY SMALL AMOUNT ACTIVE
TO AFFECTED AREA TWICE A DAY
9) UREA 20% CREAM APPLY MODERATE AMOUNT TO AFFECTED AREA ACTIVE
TWICE A DAY ONLY TO RIGHT LEG WHERE THERE IS SCALE
TWICE A DAY ONLY TO RIGHT LEG WHERE THERE IS SCALE

FH/SH:
SH notable for poor support, no phone

INTERVAL LABS/PATHOLOGY STUDIES:

BLOOD	07/15 2011 09:43	07/11 2011 06:00	07/10 2011 06:00	07/09 2011 06:00	07/08 2011 06:00	Units	Reference Ranges
WBC	7.7	8.0	7.2	6.5	7.1	THOU/CUMM	4.8 - 10.8
RBC	2.77 L	3.13 L	3.06 L	3.05 L	3.00 L	MIL/CUMM	4.2 - 6.1
HGB	9.0 L	10.0 L	9.9 L	9.8 L	9.8 L	g/dL	12 - 18
HCT	25.9 L	29.6 L	28.6 L	28.5 L	28.6 L	%	37 - 51
MCV	93.6	94.5	93.5	93.6	95.2	fL	81 - 99
MCH	32.6 H	32.0 H	32.4 H	32.3 H	32.6 H	PG	27 - 31
MCHC	34.8	33.8	34.7	34.5	34.2	G/dL	33.0 - 38.0
RDW	14.0	14.1	13.9	14.0	14.0	%	11.5 - 14.5
PLT	109 L	98 L	103 L	108 L	112 L	THOU/CUMM	130 - 400

BLOOD	07/07 2011 09:58	06/30 2011 13:53	06/16 2011 09:56	05/12 2011 10:05	04/14 2011 09:36	Units	Reference Ranges
WBC	7.7	5.8	8.9	8.9	8.0	THOU/CUMM	4.8 - 10.8
RBC	2.35 L	2.12 L	2.69 L	2.41 L	2.68 L	MIL/CUMM	4.2 - 6.1
HGB	7.6 L	6.8 L*	8.8 L	7.8 L	8.8 L	g/dL	12 - 18
HCT	22.5 L	19.8 L	24.8 L	22.6 L	24.9 L	%	37 - 51
MCV	95.4	93.4	92.1	93.7	92.8	fL	81 - 99
MCH	32.3 H	32.3 H	32.9 H	32.2 H	32.8 H	PG	27 - 31
MCHC	33.8	34.6	35.7	34.4	35.4	G/dL	33.0 - 38.0
RDW	13.5	13.6	13.6	16.8 H	17.2 H	%	11.5 - 14.5
PLT	114 L	117 L	116 L	188	193	THOU/CUMM	130 - 400

SERUM	07/21 2011 08:25	07/15 2011 09:43	07/12 2011 07:00	07/11 2011 06:00	07/10 2011 19:00	Units	Reference Ranges
GLUCOSE	137 H	167 H	124 H	168 H	136 H	mg/dL	71 - 99
NA	141	141	139	136	138	mmol/L	136 - 144
K+	4.9	5.3 H	5.1	5.9 H	5.4 H	mmol/L	3.6 - 5.1
CL	110	113 H	111	109	111	mmol/L	101 - 111

Progress Notes

Printed On Jun 05, 2013

C02	22	20 L	21 L	21 L	23	mmol/L	22 - 32
BUN	79 H	87 H	71 H	68 H	59 H	mg/dL	8 - 20
CREAT	3.54 H	3.46 H	3.61 H	3.72 H	3.44 H	mg/dL	0.70 - 1.20
CA	8.8 L	8.7 L	9.1	8.9	8.6 L	mg/dL	8.9 - 10.3

SERUM	03/23 2011 15:01	12/08 2010 13:00	Units	Reference Ranges
FE SAT	79.3 H	17.9	%	13 - 45
TIBC	169 L	190 L	mcg/dL	262 - 474
IRON	134	34 L	mcg/dL	45 - 182
IRON			mcg/dL	45 - 160
IRON			UG/DL	35 - 150
TRANSFN	133 L	150 L	mg/dL	180 - 329
TRANSFN			mg/dL	200 - 400
FERRITN	369	88	ng/mL	17.9 - 464

ERUM	07/07 2011 09:58	06/30 2011 13:53	05/12 2011 10:05	04/06 2011 11:50	04/06 2011 11:49	Units	Reference Ranges
TOT PRT	7.0	6.2	6.2	5.6 L	5.4 L	g/dL	6.1 - 7.9
ALB	4.0	3.8	3.7	3.2 L	3.2 L	g/dL	3.5 - 5.2
GLOB						g/dL	2.3 - 3.5
CALCOSM						mOsm/kg	289 - 305
A/G						RATIO	1.5 - 2.5
TBILI	0.6	0.2 L	0.5	0.6	0.6	mg/dL	.4 - 2
DBILI	0.1					mg/dL	.1 - .5
ALK PHO	62	69	69	42	41	IU/L	38 - 126
AST	18	19	19	23	25	IU/L	15 - 41
ALT	18	18	13 L	15 L	17	IU/L	17 - 63

SERUM	12/19 2010 06:00	Units	Reference Ranges
CEA	1.2	ng/mL	0 - 3

Interval Radiology: No new.
7/11/11 AAA US:

Report:
Ultrasound of the abdominal aorta was performed utilizing

real-time technique.

Proximal abdominal measures 1.6 x 1.3 cm. Midabdominal aorta measures 1.2 x 1 cm. Distal abdominal aorta measures 1.4 x 1 cm. Right common iliac measures 0.7 x 0.5 cm. Left common iliac measures 0.9 x 0.8 cm. There is plaque in the wall of the abdominal aorta.

Impression:
1. No evidence of an abdominal aortic aneurysm.

7/11/11 Renal US:

Impression:
1. Findings consistent with bilateral medical renal disease. 2. There is no hydronephrosis involving either kidney.

5/12/11 Abdominal US:
The liver measures 13.3 cm length which is not enlarged. There is increased hepatic echogenicity in keeping with nonspecific hepatocellular disease. No gross space occupying intrahepatic lesions are identified.

The spleen measures 10 cm in length which is not enlarged.

Limited Doppler images show normal directional blood flow in the portal vein. Portal vein measures 0.6 cm in diameter which is within normal limits.

The pancreas is incompletely visualized.

The right kidney measures 10.5 cm in length. There is no right hydronephrosis. The left kidney measures 10.4 cm in length. There is no left hydronephrosis. There are bilateral renal calcifications.

The gallbladder appears unremarkable. No gallstones or pericholecystic fluid is identified.. The extrahepatic bile duct measures 0.2 cm in diameter, which is within normal limits. There is no intrahepatic biliary ductal dilatation.

Impression:
Bilateral renal calcifications. No hydronephrosis.

5/11/11 PET-CT (compared to 2/2011):
Impression:
1. A new focal uptake in the left liver is suspicious for

Progress Notes

metastasis. Close follow up is recommended.
2. Interval further decreased FDG uptake in the left side wall of the rectosigmoid region, indicating significant metabolic response to recent therapy.
3. Multiple inguinal nodes with mild FDG uptake, essentially not changed from prior study.

5/11/11 CT C/A/P no IVC (due to Cr):
No clear evidence of metastatic spread of rectal cancer to the patient's chest.

The base of the lungs are clear. The heart is normal in size in this patient who is status post CABG. The heart muscle is well visualized in this noncontrast CT scan consistent with the patient's known anemia.

The unenhanced liver, spleen, and adrenal glands are normal in appearance. The pancreas appears atretic.

There are bilateral small punctate renal calcifications most consistent with nonobstructive renal calculi.

The distal rectum appears again to be slightly thickened although almost impossible to evaluate on this noncontrast CT scan, with its questionable thickening possibly a result of radiation.

There is no evidence of abdominal, pelvic, retroperitoneal lymphadenopathy. There is no evidence of bowel obstruction or adynamic ileus.

The prostate gland is mildly enlarged.

There are bilateral fat containing inguinal hernias.

Degenerative changes are visualized in the spine.

PHYSICAL EXAM:
VS reviewed. Normotensive. Weight stable.
Latino Male, NAD
Anicteric, OP Clear. Poor dentition.
Port site C/D/I over right chest wall
No cervical/supraclav/axillary LAD
Normal BS bilaterally
nl s1 s2 no mrg
abd soft, no hsm, no ttp
Cracked skin, hyperpigmentation bilateral lower ext- dressed bilaterally.

Progress Notes

IMPRESSION/PLAN: 64 yo WM h/o CAD, CKD with a high rectal adenocarcinoma incompletely staged but without evidence of distant mets, s/p partial removal of primary via EMR. Despite the absence of adenopathy or known T3/T4 lesion as clear indication for neoadjuvant therapy, proceeded with concurrent chemorads as we won't be able to determine nodal extent/T stage at this juncture. Initially was concerned about possible concomitant cecal lesion, but PET-CT showed resolution of previously noted uptake at this site and though we have not been able to get ahold of Hahnehmann c-scope for additional corroboration, I'm more comfortable that this was a false positive, particularly in light of attempt at direct visualization here already. Course during therapy c/b n/v/AKD, anemia, and port site hypersensitivity. Has completed neoadjuvant chemorads.

Restaging studies show reduction in primary mass; PET-CT raised concern for possible uptake in liver but his noncon CT C/A/P and US of the abdomen did not visualize any liver lesions, LFTs are normal, no abdominal pain.

1. Rectal adenocarcinoma:
-Completed neoadjuvant chemorads as of 4/7/11.
-Completed EUS and Flex sig 6/2011
-Although PET-CT showed mild liver uptake,his dedicated CT and the US showed no lesions in the liver to correspond to are of uptake; t/c intraoperative US
-Has upcoming surgical oncology evaluation on 8/15/11 with Dr. Mahmoud to schedule his procedure. June 21 he will learn when that appt is, but OR date still not scheduled. Hopefully will be expedited given length of time now from completion of neoadjuvant therapy 4 MONTHS AGO and radiologic concern over liver.
-Will anticipate treating with adjuvant chemotherapy postop
-The length of time that elapsed since submission of 7078 form and granting of appointment at HUP is unacceptable. Will direct complaint towards administration. Standard of care is that resection take place 5-10 weeks after completion of definitive chemoradiotherapy. Forms were submitted in due time by surgical oncology here but it appears the delay occured during point in process where a "number" needed to be granted to confirm payment from the VA system to HUP. Thankfully the inpatient team identified the delay was due to this and pushed for a date.
-Will contact Dr. Mahmoud to clarify staging issues and hopefully to expedite OR date.
-RTC mid August to confirm he has had OR date settled and in case he needs repeat restaging

2. Anemia: Occult blood losses, CKD, + chemorads. Ultimately was planning for iron infusions/Venofer given CKD and blood loss, but in the interim he got an iron load with his transfusions. Iron replete as of now; no ESA despite CKD given active malignancy on curative chemotherapy. Has needed intermittent blood transfusions; poor reserve given CKD and chemorads. Transfused again last week; no obvious signs of loss.
-Monitor

Progress Notes

3. AKI on CKD: Poor po, GI losses, HTN, exacerbated by anemia. Suboptimal bp control on Amlodipine and Ace-I and betablocker.
-Repeat Ocomp in 2 weeks
-Continue renal follow-up; no biopsy for now.
-Hold Lasix
-Hold ACE-I. Renal had suggested temporarily stopping his ACE-I near time of surgery to reduce risk of prerenal insult prior to OR; instructed patient today to change his meds as follows to try to control BP but to reduce potential renal insult
-Cont Amlodipine 10mg po qd
-Atenolol 25mg po bid

4. Nausea, weight loss: Stabilized

5. CAD:
-Monitor closely for vasospasm symptoms with 5-FU
-Off Plavix
-Off ASA,
-Cont ACE-I, statin

6. Port site pain: Looks fine, not sure why he is having so much discomfort there. He says today pain is "all over." Urged him to cut back and will limit amount of Percocet we distribute; he stops taking it once he has run out.
-Max 1 tab q8prn; dispensed 60 tabs.
-Suspect he will need meds in context of OR.
-When we resume adjuvant therapy, will use EMLA cream.

7. Phone contact:
-touched base with social work; he is to go there and sign an income form today.
-Hopefully will get cell soon

/es/ KEERTHI GOGINENI
Intern
Signed: 07/21/2011 17:02

LOCAL TITLE: NURSING NOTE
STANDARD TITLE: NURSING NOTE
DATE OF NOTE: JUL 19, 2011@11:22 ENTRY DATE: JUL 19, 2011@11:22:29
AUTHOR: FREE,WILLIAM M EXP COSIGNER:
URGENCY: STATUS: COMPLETED

ORDER WRITTEN 04/28/11
ORDER EXPIRES AFTER SEPTEMBER 2011 INJECTION.

EXHIBIT K

Progress Notes

Vital signs @ 15 minutes (15:15): T 98.2 HR 56 RR 16 B/P 138/51
@ COMPLETION (16:00): T 98.1 HR 57 RR 18 B/P 162/74

Patient tolerance/reactions: PATIENT TOLERATED TRANSFUSION WITHOUT COMPLICATIONS. PATIENT'S PORT WAS FLUSHE(10ML NSS AND 500UNITS HEPARIN FLUSH)

Orientation:AAOX3

Time discontinued: 16:00

Post transfusion instructions:GO TO THE ER IF DEVELOP FEVER, CHILLS, SOB
Discharged via:
Ambularoty: X Ambulance: Wheelchair:

Physician's written order: YES

/es/ JESSICA L FRISCIA
RN, OCN
Signed: 08/25/2011 15:59

LOCAL TITLE: HEM/ONC ATTENDING PROGRESS NOTE
STANDARD TITLE: HEMATOLOGY AND ONCOLOGY ATTENDING NOTE
DATE OF NOTE: AUG 25, 2011@10:52 ENTRY DATE: AUG 25, 2011@10:52:13
AUTHOR: GOGINENI,KEERTHI EXP COSIGNER:
URGENCY: STATUS: COMPLETED

OUTPATIENT HEMATOLOGY-ONCOLOGY VISIT:8/25/11

LAST SEEN:7/21/11

DIAGNOSIS: Rectal adenocarcinoma

STAGE:TXNXM0
No EUS performed due to ?distortion after EMR which unexpectedly demonstrated adenocarcinoma.

PRIOR TREATMENTS:
Status post neoadjuvant chemorads
Cycle 1 (2/14-2/18/11):5-FU 1000MG/M2=1660MG PER DAY FOR 5 DAYS
Cycle 2 (3/21-3/25/11): 5-FU 1000MG/M2=1660MG PER DAY FOR 5 DAYS (technically one week delay, i.e. day 34 instead of day 29 because of missed RT days)
Completed RT 4/7/11: 5040cGy

Progress Notes

6/9/11 had EUS and flex sig procedure with Dr. Lieb:
EUS Impression:
1.Some thicking for about 10-15 cm in the rectal wall, starting about 3cm from anal verge involving layer 2. This is almost certainly post radiation changes. Musculars propria and deeper rectal layers intact and unaffected as above.
2.No visible local/regional adenopathy.

Flex sig
Impression:
Scar seen in rectum as above with likely small amount of residual adenomatous appearing tissue.
Recommendations:
Follow up with medical oncology and surgery service.

CURRENT TREATMENT: Awaiting surgery!

ECOG STATUS:0

HPI/INTERVAL HISTORY: Mr. Delgado is a 64 yo gentleman with history of coronary disease s/p 4V CABG in 3/2010 who was subsequently managed on ASA & Plavix who has a rectal adenocarcinoma. He had a colonoscopy in 2007 demonstrating rectal adenoma, and was lost to follow-up thereafter until he presented with syncope resulting in the cardiac evaluation/CABG in 3/2010. At that time, he reports having had a c-scope at Hahnemann. I have not seen this report. Coordination of his procedures and prep has been complicated by nonexistant social support, no phone, blood thinners, poor preps, etc. Ultimately re-evaluated at the VA in 12/9/2010, and c-scope then apparently showed a lesion 7cm from the anal verge that looked like a polypoid adenoma. Mass was not biopsied at that time as he was on ASA and Plavix, and plan was for follow-up EMR/EUS and biopsy as well as repeat evaluation of remaining colon given poor prep. He had a repeat C-scope on 12/20- he had ~80% of the lesion removed via EMR; EUS was not performed. Unexpectedly, biopsy of the mass showed a focus of adenocarcinoma arising from a TV adenoma. He had a PET-CT on 12/21 (one day after his procedure) showing SUV max 16.9 at the proximal rectum/distal sigmoid colon and soft tissue density measuring 41 x 29 mm in the cecum / proximal ascending colon with diffuse tracer uptake (max SUV of 5.0). Dr. Lieb in retrospect mentioned possible abrasion at the cecum due to instrumentation corresponding to this uptake. Tumor board discussion (at which I was not present) culminated in decision to proceed with neoadjuvant therapy due to bulk of the lesion as visualized on c-scope as EUS at this time post EMR was felt to offer limited utility re depth of invasion of residual lesion and despite unknown extent/presence of nodal involvement.

Today:
He saw Dr. Mahmoud on 8/15.
Unfortunately, no medical records were provided to Dr. Mahmoud's office prior to this visit. He was told that records were necessary prior to further planning.

Progress Notes

No follow-up appointment was set.
He was very upset; tearful after this. Felt like he wanted to drink/get high; frustrated after waiting so long for this evaluation.

He did manage to get a cell phone from CSW.(215)432-2419

He is to see Sandra Hayes and surgical oncology today.

Feels tired, dizzy. Hg low again. He admits to seeing dark stool. No frank blood. Has seen this over last 10 days.

He feels diffuse pain. Says he ran out of Oxycodone because I provided less at last visit with instructions to titrate down; no clear source for pain.

PMH:
CKD (baseline pretreatment was Cr 2.55)
DM
CAD (preserved EF)

ALL:NKDA

RX:

1)	ACCU-CHEK COMFORT CV(GLUCOSE) TEST STRIP USE 1 STRIP FOR TESTING TWICE A WEEK	ACTIVE
2)	AMLODIPINE BESYLATE 10MG TAB TAKE ONE TABLET BY MOUTH ONCE DAILY (NOTE THE DOSAGE/STRENGTH)HIGHER DOSE	ACTIVE
3)	ATENOLOL 25MG TABLET TAKE ONE TABLET BY MOUTH TWICE A DAY	ACTIVE
4)	DERMA CERIN TOP CREAM APPLY SMALL AMOUNT TO AFFECTED AREA DAILY	ACTIVE
5)	ERGOCALCIFEROL (VIT D2) 50,000UNIT CAP TAKE ONE CAPSULE BY MOUTH WEEKLY FOR VITAMIN D REPLACEMENT	ACTIVE
6)	OXYCODONE HCL/ACETAMINOPHEN 5/325 TAB TAKE 1 TABLET BY MOUTH EVERY 8 HOURS AS NEEDED	ACTIVE
7)	ROSUVASTATIN CA 40MG TAB TAKE ONE-HALF TABLET BY MOUTH ONCE DAILY FOR CHOLESTEROL IN PLACE OF SIMVASTATIN.	ACTIVE
8)	TRIAMCINOLONE ACETONIDE 0.1% CREAM APPLY SMALL AMOUNT TO AFFECTED AREA TWICE A DAY	ACTIVE
9)	UREA 20% CREAM APPLY MODERATE AMOUNT TO AFFECTED AREA TWICE A DAY ONLY TO RIGHT LEG WHERE THERE IS SCALE	ACTIVE

FH/SH:
SH notable for poor support, no phone

INTERVAL LABS/PATHOLOGY STUDIES:

Progress Notes

BLOOD	08/25 2011 08:18	07/15 2011 09:43	07/11 2011 06:00	07/10 2011 06:00	07/09 2011 06:00	Units	Reference Ranges
WBC	7.1	7.7	8.0	7.2	6.5	THOU/CUMM	4.8 - 10.8
RBC	2.16 L	2.77 L	3.13 L	3.06 L	3.05 L	MIL/CUMM	4.2 - 6.1
HGB	7.0 L	9.0 L	10.0 L	9.9 L	9.8 L	g/dL	12 - 18
HCT	19.7 L	25.9 L	29.6 L	28.6 L	28.5 L	%	37 - 51
MCV	91.0	93.6	94.5	93.5	93.6	fL	81 - 99
MCH	32.1 H	32.6 H	32.0 H	32.4 H	32.3 H	PG	27 - 31
MCHC	35.3	34.8	33.8	34.7	34.5	G/dL	33.0 - 38.0
RDW	13.9	14.0	14.1	13.9	14.0	%	11.5 - 14.5
PLT	129 L	109 L	98 L	103 L	108 L	THOU/CUMM	130 - 400

SERUM	08/25 2011 08:18	07/21 2011 08:25	07/15 2011 09:43	07/12 2011 07:00	07/11 2011 06:00	Units	Reference Ranges
GLUCOSE	179 H	137 H	167 H	124 H	168 H	mg/dL	71 - 99
NA	139	141	141	139	136	mmol/L	136 - 144
K+	4.4	4.9	5.3 H	5.1	5.9 H	mmol/L	3.6 - 5.1
CL	110	110	113 H	111	109	mmol/L	101 - 111
C02	21 L	22	20 L	21 L	21 L	mmol/L	22 - 32
BUN	68 H	79 H	87 H	71 H	68 H	mg/dL	8 - 20
CREAT	3.00 H	3.54 H	3.46 H	3.61 H	3.72 H	mg/dL	0.70 - 1.20
CA	8.7 L	8.8 L	8.7 L	9.1	8.9	mg/dL	8.9 - 10.3

SERUM	03/23 2011 15:01	12/08 2010 13:00	Units	Reference Ranges
FE SAT	79.3 H	17.9	%	13 - 45
TIBC	169 L	190 L	mcg/dL	262 - 474
IRON	134	34 L	mcg/dL	45 - 182
IRON			mcg/dL	45 - 160
IRON			UG/DL	35 - 150
TRANSFN	133 L	150 L	mg/dL	180 - 329
TRANSFN			mg/dL	200 - 400
FERRITN	369	88	ng/mL	17.9 - 464

SERUM	08/25 2011 08:18	07/07 2011 09:58	06/30 2011 13:53	05/12 2011 10:05	04/06 2011 11:50	Units	Reference Ranges
TOT PRT	7.1	7.0	6.2	6.2	5.6 L	g/dL	6.1 - 7.9
ALB	4.1	4.0	3.8	3.7	3.2 L	g/dL	3.5 - 5.2
GLOB						g/dL	2.3 - 3.5

Progress Notes

CALCOSM						mOsm/kg	289 - 305
A/G						RATIO	1.5 - 2.5
TBILI	0.6	0.6	0.2 L	0.5	0.6	mg/dL	.4 - 2
DBILI		0.1				mg/dL	.1 - .5
ALK PHO	83	62	69	69	42	IU/L	38 - 126
AST	16	18	19	19	23	IU/L	15 - 41
ALT	13 L	18	18	13 L	15 L	IU/L	17 - 63

SERUM	12/19 2010 06:00	Units	Reference Ranges
CEA	1.2	ng/mL	0 - 3

Interval Radiology: No new.
7/11/11 AAA US:

Report:
Ultrasound of the abdominal aorta was performed utilizing real-time technique.

Proximal abdominal measures 1.6 x 1.3 cm. Midabdominal aorta measures 1.2 x 1 cm. Distal abdominal aorta measures 1.4 x 1 cm. Right common iliac measures 0.7 x 0.5 cm. Left common iliac measures 0.9 x 0.8 cm. There is plaque in the wall of the abdominal aorta.

Impression:
1. No evidence of an abdominal aortic aneurysm.

7/11/11 Renal US:

Impression:
1. Findings consistent with bilateral medical renal disease. 2. There is no hydronephrosis involving either kidney.

5/12/11 Abdominal US:
The liver measures 13.3 cm length which is not enlarged. There is increased hepatic echogenicity in keeping with nonspecific hepatocellular disease. No gross space occupying intrahepatic lesions are identified.

The spleen measures 10 cm in length which is not enlarged.

Limited Doppler images show normal directional blood flow in the

portal vein. Portal vein measures 0.6 cm in diameter which is within normal limits.

The pancreas is incompletely visualized.

The right kidney measures 10.5 cm in length. There is no right hydronephrosis. The left kidney measures 10.4 cm in length. There is no left hydronephrosis. There are bilateral renal calcifications.

The gallbladder appears unremarkable. No gallstones or pericholecystic fluid is identified.. The extrahepatic bile duct measures 0.2 cm in diameter, which is within normal limits. There is no intrahepatic biliary ductal dilatation.

Impression:
Bilateral renal calcifications. No hydronephrosis.

5/11/11 PET-CT (compared to 2/2011):
Impression:
1. A new focal uptake in the left liver is suspicious for metastasis. Close follow up is recommended.
2. Interval further decreased FDG uptake in the left side wall of the rectosigmoid region, indicating significant metabolic response to recent therapy.
3. Multiple inguinal nodes with mild FDG uptake, essentially not changed from prior study.

5/11/11 CT C/A/P no IVC (due to Cr):
No clear evidence of metastatic spread of rectal cancer to the patient's chest.

The base of the lungs are clear. The heart is normal in size in this patient who is status post CABG. The heart muscle is well visualized in this noncontrast CT scan consistent with the patient's known anemia.

The unenhanced liver, spleen, and adrenal glands are normal in appearance. The pancreas appears atretic.

There are bilateral small punctate renal calcifications most consistent with nonobstructive renal calculi.

The distal rectum appears again to be slightly thickened although almost impossible to evaluate on this noncontrast CT scan, with its questionable thickening possibly a result of radiation.

Progress Notes

There is no evidence of abdominal, pelvic, retroperitoneal lymphadenopathy. There is no evidence of bowel obstruction or adynamic ileus.

The prostate gland is mildly enlarged.

There are bilateral fat containing inguinal hernias.

Degenerative changes are visualized in the spine.

PHYSICAL EXAM:
VS reviewed. Weight stable.
Latino Male, NAD
Anicteric, OP Clear. Poor dentition.
Port site C/D/I over right chest wall
No cervical/supraclav/axillary LAD
Normal BS bilaterally
nl s1 s2 no mrg
abd soft, no hsm, no ttp
Cracked skin, hyperpigmentation bilateral lower ext- dressed bilaterally.

IMPRESSION/PLAN: 64 yo WM h/o CAD, CKD with a high rectal adenocarcinoma incompletely staged but without evidence of distant mets, s/p partial removal of primary via EMR. Despite the absence of adenopathy or known T3/T4 lesion as clear indication for neoadjuvant therapy, proceeded with concurrent chemorads as couldn't determine nodal extent/T stage at this juncture. Initially was concerned about possible concomitant cecal lesion, but PET-CT showed resolution of previously noted uptake at this site and though we have not been able to get ahold of Hahnehmann c-scope for additional corroboration, I'm more comfortable that this was a false positive, particularly in light of attempt at direct visualization here already. Course during therapy c/b n/v/AKD, anemia, and port site hypersensitivity. Has completed neoadjuvant chemorads.

Restaging studies show reduction in primary mass; PET-CT raised concern for possible uptake in liver but his noncon CT C/A/P and US of the abdomen did not visualize any liver lesions, LFTs are normal, no abdominal pain.

1. Rectal adenocarcinoma:
-Completed neoadjuvant chemorads as of 4/7/11.
-Completed EUS and Flex sig 6/2011
-Although PET-CT showed mild liver uptake,his dedicated CT and the US showed no lesions in the liver to correspond to are of uptake; t/c intraoperative US
-Will anticipate treating with adjuvant chemotherapy postop
-Unfortunately, no records were provided to HUP to help inform his surgical planning and as far as I can tell, still no OR date 5 months out from completion of neoadjuvant chemorads. Standard of care is that resection take place 5-10 weeks after completion of definitive chemoradiotherapy. Forms

Progress Notes

were submitted in due time by surgical oncology here but it appears the delay occured during point in process where a "number" needed to be granted to confirm payment from the VA system to HUP.
-To see surg onc at the VA after this appt; will talk to the team about coordination of his follow-up at HUP. Unfortunately, although we asked him to stop by the surgical oncology clinic for evaluation once he had a T&S drawn, he ended up coming back upstairs after without having been evaluated and has not been seen today. Spoke with Sandra Hayes; plan is to restage him (they will be ordering the scans), have him formally seen by Dr. Paulsen here, and anticipate OR in September.

2. Anemia: Appears to have sympotmatic ongoing bleeding; also has low reserve given CKD; cytopenic from chemorads. No ESA despite CKD given active malignancy on curative chemotherapy. Has needed
intermittent blood transfusions; poor reserve given CKD and chemorads.
-Will need transfusion, he is symptomatic.

3. AKI on CKD: Poor po, GI losses, HTN, exacerbated by anemia. Suboptimal bp control on Amlodipine and Ace-I and betablocker.
-Follow Ocomp
-Continue renal follow-up; no biopsy for now.
-Continue to hold Lasix and ACE-I. Renal had suggested temporarily stopping his ACE-I near time of surgery to reduce risk of prerenal insult prior to OR
-Amlodipine 10mg po qd
-Atenolol 25mg po bid

4. Nausea, weight loss: Stabilized

5. CAD:
-Monitor closely for vasospasm symptoms with 5-FU
-Off Plavix
-Off ASA, ACE-I
-Cont statin

6. Port site pain: Looks fine, continues to c/o diffuse pain. He has been dependent on Percocet. Asked him to cut back but continues to have pain requirements.
-Max 1 tab q8prn. Dispensed 90 tabs today.
-Suspect he will need meds in context of OR.
-When we resume adjuvant therapy, will use EMLA cream.

7. Phone contact:
-Needs to update system re new cell number:(215)432-2419

/es/ KEERTHI GOGINENI
Intern

EXHIBIT L

Surgical Information

Printed On Jun 05, 2013

Signed: 03/07/2012 16:45
for MACHELLE NELSON
RN

OPERATION REPORT

LOCAL TITLE: OPERATION REPORT
STANDARD TITLE: OPERATIVE REPORT
DICT DATE: SEP 09, 2011 ENTRY DATE: SEP 09, 2011@15:13:59
SURGEON: PAULSON,EMILY CARTE ATTENDING: PAULSON,EMILY CARTER
URGENCY: priority STATUS: COMPLETED
SUBJECT: Case #: 60697

DATE OF BIRTH: April 23, 1946.

PREOPERATIVE DIAGNOSIS: Rectal Cancer

POSTOPERATIVE DIAGNOSIS: rectal Cancer

PROCEDURE: Examination under anesthesia.

ATTENDING SURGEON: Dr. Paulson

ASSISTANT: Dr. Dancer

ESTIMATED BLOOD LOSS: 0 mL.

COMPLICATIONS: None.

TUBES: None.

SPECIMENS: None.

FLUIDS: 150 mL using a peripheral IV.

DISPOSITION: The patient returned to the ward.

FINDINGS: Inability to visualize the rectal tumor.

INDICATIONS FOR PROCEDURE: The patient is a 65-year-old gentleman with a history of chronic kidney disease, hypertension, diabetes, nephrocalcinosis, history of coronary artery disease status post CABG x4, with rectal cancer status post neoadjuvant chemotherapy. He was seen previously in our clinic and set up for an examination under anesthesia with transanal excision of residual polypooid tissue seen on flex sig following

Surgical Information

completion of his chemotherapy.

DESCRIPTION OF PROCEDURE: The patient was taken to the operating room on September 9, 2011. While in the operating room, a timeout was performed with the appropriate members of the operating room staff. The patient, procedure, and the site were identified. Anesthesia placed spinal anesthesia, and the patient was positioned in a prone jackknife position. The patient'e buttocks were taped apart and were prepped and draped in a sterile fashion. The examination under anesthesia was performed using digital examination and anoscopic examination However, no tumor could be appreciated. At that time, the procedure was terminated, and the decision was made to have the patient potentially evaluated by GI for a flexible sigmoidoscope early next week. At the end of the procedure, all sponge and instrument counts were correct. The patient was brought back to the PACU. He tolerated the procedure well.

50534847/2110272(09/09/2011)39680751
$END

/es/ EMILY CARTER PAULSON
ATTENDING GI SURGEON
Signed: 09/12/2011 08:19

NURSE INTRAOPERATIVE REPORT

LOCAL TITLE: NURSE INTRAOPERATIVE REPORT
STANDARD TITLE: NURSING OPERATIVE NOTE
DATE OF NOTE: SEP 09, 2011@14:22 ENTRY DATE: SEP 09, 2011@15:13:59
AUTHOR: ENRIQUEZ,MEDY B EXP COSIGNER:
URGENCY: STATUS: COMPLETED
SUBJECT: Case #: 60697

Operating Room: OR4 Surgical Priority: ELECTIVE

Patient in Hold: NOT ENTERED Patient in OR: SEP 09, 2011 14:22
Operation Begin: SEP 09, 2011 14:42 Operation End: SEP 09, 2011 14:51
Patient Out OR: SEP 09, 2011 15:00

Minor Operations Performed:
Primary: EUA

Wound Classification: DIRTY/INFECTED
Operation Disposition: PACU (RECOVERY ROOM)
Discharged Via: STRETCHER

Surgeon: PAULSON,EMILY CARTER First Assist: DANZER,ENRICO
Attend Surg: PAULSON,EMILY CARTER Second Assist: N/A
Anesthetist: PAUL,PUSHPA Assistant Anesth: N/A

Surgical Information

Printed On Jun 05, 2013

Other Scrubbed Assistants: N/A

OR Support Personnel:

Scrubbed	Circulating
N/A	ENRIQUEZ,MEDY B (FULLY TRAINED)

Other Persons in OR:
RAYNA BOSTICK (ORT, AGENCY)

Preop Mood: ANXIOUS
Preop Consc: ALERT-ORIENTED
Preop Skin Integ: INTACT
Preop Converse: N/A
Confirm Correct Patient Identity: YES
Confirm Procedure to be Performed: YES
Confirm Site of the Procedure, including laterality: YES
Confirm Valid Consent Form: YES
Confirm Patient Position: YES
Confirm Procedure Site has been Marked Appropriately and that the Site of the Mark is Visible After Prep and Draping: YES
Pertinent Medical Images have been Confirmed: YES
Correct Medical Implant(s) is available: NO
Availability of Special Equipment: YES
Appropriate Antibiotic Prophylaxis: YES
Appropriate Deep Vein Thrombosis Prophylaxis: NO
Blood Availability: NO
Checklist Comment:
1426 TIME OUT DONE

Checklist Confirmed By: ENRIQUEZ,MEDY B

Skin Prep By: PAULSON,EMILY CARTER
Skin Prep Agent: POVIDONE IODINE PAINT
Skin Prep By (2): N/A
2nd Skin Prep Agent: N/A

Preop Surgical Site Hair Removal by: N/A
Surgical Site Hair Removal Method: NO HAIR REMOVED
Hair Removal Comments: NO COMMENTS ENTERED

Surgery Position(s):

SUPINE	Placed: N/A
PRONE	Placed: N/A

Restraints and Position Aids:

SAFETY STRAP	Applied By: ENRIQUEZ,MEDY B
FOAM PADS	Applied By: ENRIQUEZ,MEDY B
PILLOW	Applied By: ENRIQUEZ,MEDY B

Electrocautery Unit: N/A
ESU Coagulation Range: N/A

Surgical Information

ESU Cutting Range: N/A
Electroground Position(s): LEFT ANT THIGH

Material Sent to Laboratory for Analysis:
Specimens: N/A
Cultures: N/A

Anesthesia Technique(s):
SPINAL (PRINCIPAL)
MONITORED ANESTHESIA CARE

Tubes and Drains:
N

Tourniquet: N/A

Thermal Unit: N/A

Prosthesis Installed: N/A

Medications:
SURGILUBE

Irrigation Solution(s):
NORMAL SALINE

Blood Replacement Fluids: N/A

Sponge Count Correct: YES
Sharps Count Correct: YES
Instrument Count Correct: NOT APPLICABLE
Counter: ENRIQUEZ,MEDY B
Counts Verified By: ENRIQUEZ,MEDY B

Dressing: N
Packing: NONE

Blood Loss: 0 ml Urine Output: 0 ml

Postoperative Mood: RELAXED
Postoperative Consciousness: ALERT-ORIENTED
Postoperative Skin Integrity: INTACT
Postoperative Skin Color: N/A

Laser Unit(s): N/A

Sequential Compression Device: NO

Surgical Information

Cell Saver(s): N/A

Devices: N/A

Nursing Care Comments:
RAYNA BOSTICK, ST IS THE PERSON RESPONSIBLE FOR THE FINAL COUNT

/es/ MEDY B ENRIQUEZ,RN
STAFF NURSE OR X6677
Signed: 09/09/2011 15:16

OPERATION REPORT

LOCAL TITLE: OPERATION REPORT
STANDARD TITLE: OPERATIVE REPORT
DICT DATE: SEP 11, 2007 ENTRY DATE: SEP 11, 2007@09:33:27
SURGEON: SULEWSKI,MICHAEL E ATTENDING: SULEWSKI,MICHAEL E
URGENCY: routine STATUS: COMPLETED
SUBJECT: Case #: 45076

PREOPERATIVE DIAGNOSIS: Cataract in the left eye.

POSTOPERATIVE DIAGNOSIS: Cataract in the left eye.

PROCEDURE: Phacoemulsification and intraocular lens placement, left eye.

RESIDENT SURGEON: Dr. Tamiesha Frempong.

ANESTHESIA: Monitored anesthesia care with retrobulbar block consisting of 2 cc of 2% lidocaine and 2 cc of 0.75% Marcaine.

COMPLICATIONS: None.

PROCEDURE: The patient was identified in the Preoperative Holding Area as R. Jesus Delgado and the left eye was agreed on and marked
as the operative eye.

The patient was brought into the Operating Room and placed on the operative table in a supine position. Monitored anesthesia care was then initiated and a retrobulbar block was delivered. A time-out was done in the Operating Room to confirm the patient's left eye, and the patient was prepped and draped in the usual sterile ophthalmic fashion.

EXHIBIT M

Progress Notes

edema. lung sounds CTA on room air. Skin intact. Will continue to monitor.

17:30 Post surgical void 150ml clear yellow urine.

21:00-24:00 Patient's blood sugar 330, 6units Aspart SQ administered as per sliding scale. No other changes noted.

/es/ TAMIKA SMITH
RN
Signed: 09/09/2011 21:44

09/09/2011 ADDENDUM STATUS: COMPLETED
17:18 Patient's blood sugar 122, no sliding scale coverage required

/es/ TAMIKA SMITH
RN
Signed: 09/09/2011 21:46

LOCAL TITLE: SURGERY RESIDENT PROGRESS NOTE
STANDARD TITLE: SURGERY RESIDENT NOTE
DATE OF NOTE: SEP 09, 2011@15:23 ENTRY DATE: SEP 09, 2011@15:23:29
AUTHOR: DANZER,ENRICO EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Date/Time: Sep 9,2011@15:19

Pre-Operative Diagnosis: Rectal tumor

Post-Operative Diagnosis: same

Procedure: EUA

Surgeon(s): Dr. Paulson

Assistants: Dr. Danzer

Anesthesia: spinal

EBL: 0 cc

Findings: inability to visualize rectal tumor

Complications and Their Management:none

Tubes/Drains: none

Progress Notes

Specimens Sent to Pathology: none

Specimens Sent to Microbiology: none

Fluids: 150cc

IV Lines: PIV

Disposition: return to Ward

VTE risk assessment:
Moderate risk for venous thromboembolism
NO contraindications to anticoagulation prophylaxis of VTE.

/es/ ENRICO DANZER
general surgery resident
Signed: 09/09/2011 15:23

LOCAL TITLE: ANESTHESIA INTRA-OPERATIVE RECORD
STANDARD TITLE: ANESTHESIOLOGY OPERATIVE NOTE
DATE OF NOTE: SEP 09, 2011@15:15 ENTRY DATE: SEP 09, 2011@15:15:14
AUTHOR: PAUL,PUSHPA EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Patient: DELGADO, RAUL
SSN: 281-42-8155

Date of Operation: 2011-09-09

Surgery Start Time: 2011-09-09 14:42:42
Surgery End Time: 2011-09-09 14:51:11

Anesthesia Care Start: 2011-09-09 14:22:54
Anesthesia Care End: 2011-09-09 15:12:00

ASA Number: 3

/es/ USER SAVLINK
SAVLINK TIU SERVICE

EXHIBIT N

Progress Notes

STANDARD TITLE: GASTROENTEROLOGY PROCEDURE CONSULT
DATE OF NOTE: SEP 13, 2011@10:12 ENTRY DATE: SEP 13, 2011@10:12:37
AUTHOR: LIEB,JOHN G EXP COSIGNER:
URGENCY: STATUS: COMPLETED

*** GI FLEX SIG CONSULT* Has ADDENDA ***

Patient Name & SSN: DELGADO,RAUL JESUS 281-42-8155
Indication:rectal ca for surveilance and if residual adenoma, for retreatment.
Physician performing the procedure:John Lieb II MD
Mike Bennet RN, Gillian Robinson tech
Location of procedure: GI Endoscopic Unit
Medication:
2mg versed/50mcg fentanyl in one dose. This made him quite sleepy.
Procedure:
After go lytely prep and under continuous cardiopulmonary monitorring, the scope was inserted through the anus without difficulty. Though the rectal and scope insertion were somewhat painful for pt even though he fell back asleep immediately.
The scope was advanced to the distal sigmoid colon at 20cm with a mininal air insufflation.
The examination was completed.
The patient tolerated the procedure well.
The quality of the prep was fair but was lavaged in the important area to good.

The details of the findings were as follows:
Rectum: As before in the same location (see last note in June for more details), the lesion was present with adjacent scar.Residual lesion was small, about 7mm and almost identical to last exam in June, probably residual adenoma. There was also a nearby scar with some hyperplastic appearing tissue around the scar. I removed the residual flat, red, adenomatous appearing tissue with bites of jumbo forceps. Then I APCed this area with conmed at 1L/min and 30W to good effect. No more residual seemed to be present.This material was placed in jar #1, "residual rectal polyp" Then I biopsied the scar site and surrounding mucosa with the hyperplastic looking areas into jar #2 with the jumbo forceps ("rectal scar"). This area too was gently APCed with similar settings. Then I injected a Submucosal tattoo with SPOT, about 1.5cc just distal to the lesion to facillitate location during proctoscopy, should that be necessary.

There were some radiation effects, especially right near the dentate with some small telengectasias, really not enough and too close to dentate to warrant APC.

Sigmoid colon: Normal mucosa in the distal most areas which were the only parts of sigmoid seen. Except melanosis coli was present.

Progress Notes

Descending colon: did not enter.

Impression:
1.Some residual tissue present, likely just adenoma, likely unchanged from June. Removed with cold forceps and fulgurated with APC.
2.Adjacent scar site seen. Biopsied and also fulgurated. Tattooed just distal to this area

Recommendations:
1.Await pathology results.
2.Follow up with surgery service regarding hepatic lesion, possible met.
3.Agree with CEA/AFP as ordered.
4.Further recommendations per general GI consult service.
5.If pt does well with a good remission, in 2 years or so, probably warrants a repeat colonoscopy.
6.Low threshold to use empirical enteric coverage antibiotics for post polypectomy syndrome (ie house staff should be called for temp>100F and if no other source, empirical enteric antibiotics should be given for 5 days or so.

/es/ John G Lieb II M.D.
GASTROENTEROLOGY ATTENDING
Signed: 09/13/2011 10:28

Receipt Acknowledged By:

09/13/2011 11:31	/es/	MARTIN TOBI MD
09/13/2011 14:24	/es/	VESSELIN T TOMOV MD PHD FELLOW
09/23/2011 14:26	/es/	Carrie P. Ogorek MD
09/14/2011 08:24	/es/	EMILY CARTER PAULSON ATTENDING GI SURGEON
09/15/2011 08:25	/es/	KEERTHI GOGINENI Intern
09/14/2011 15:06	/es/	Diana C. Stripp, MD Attending, Radiation Oncology

09/15/2011 ADDENDUM STATUS: COMPLETED
Pathology returned:

FINAL DIAGNOSIS
I) RESIDUAL POLYP (RECTAL):
TUBULAR ADENOMA, FRAGMENTS AND NORMAL COLONIC MUCOSA, FRAGMENTS.

II) RECTAL SCAR:
FRAGMENTS OF NORMAL COLONIC MUCOSA WITH A FEW LYMPHOID

EXHIBIT O

Progress Notes

claim is denied, Mr. Delgado will have a chance to appeal. If the appeal is denied, then Mr. Delgado can appeal again, but this time the appeal would be heard in federal court. If the case goes to federal court, Mr. Delgado will need to hire and attorney. Mr. Delgado stated that he already has been in contact with an attorney. Mr. Delgado's attorney is Michael Taub from the Homeless Advocacy Project. Mr. Delgado indicated that he has spoken to Mr. Taub and that Mr. Delgado is going to go through with the claims. Ms. Kirlin provided Mr. Delgado with the application for the Administrative claim and explained how to fill out the form. Ms. Kirlin asked Mr. Delgado if he had any questions. Mr. Delgado did not have any questions. Casemanager did not have any follow up questions. Casemanager and Mr. Delgado scheduled to go to the VA benefits center on 5/23. Casemanager agreed to pick Mr. Delgado up at 9 am. Mr. Delgado signed a release of information so that casemanager could discuss the case with Mr. Michael Staub. Mr. Delgado agreed to contact Mr. Staub and have Mr. Staub contact caseworker.

/es/ Daniel W. Halstead, LSW
Social Worker
Signed: 05/21/2014 10:53

LOCAL TITLE: DISCLOSURE OF ADVERSE EVENT NOTE
STANDARD TITLE: ADVERSE EVENT NOTE
DATE OF NOTE: MAY 20, 2014@17:00 ENTRY DATE: MAY 20, 2014@17:00:33
AUTHOR: SCHAPIRA,RALPH M EXP COSIGNER:
URGENCY: STATUS: COMPLETED

*** DISCLOSURE OF ADVERSE EVENT NOTE Has ADDENDA ***

INSTITUTIONAL
Date/Time of event: Sep 19,2013@08:00
Date/Time of discussion: May 20,2014@11:30
Place of discussion: Chief of Staff conference room at Philadelphia VAMC

Names of those present: patient, Ms. Kirlin and social workers

Summary of information presented regarding adverse event: A delay in diagnosis of colon cancer which might have resulted in progression to a later stage

Offer of Assistance (including bereavement support): tort claim information provided by Mrs. Kirlin and me

Questions addressed in the discussion: Patient said he would consider options, including tort claim. He accepted the information and did not have any questions

Progress Notes

Patient and/or Surrogate Decision Maker advised of right
to compensation, i.e., 1151 or Tort? (yes)
**If no or NA, please explain: Yes, patient advised for Tort Clain

Continued communications regarding adverse event: I offered to follow-up with patient if he wishes.

/es/ RALPH M SCHAPIRA, MD
Chief of Staff (Pulmonary/Critical Care)
Signed: 05/20/2014 17:04

05/21/2014 ADDENDUM STATUS: COMPLETED
At the disclosure meeting on 5/20/14, information pertaining to 1151 claims process and the right to file an administrative tort claim was provided to the veteran. Veteran was provided a copy of the pamphlet titled "Financial Compensation After an Injury" and at his request, was provided a SF 95 Claim Form. He was also provided my contact information for any follow up questions he or his representative may have.

/es/ SUSANN M KIRLIN, RN
RISK MANAGER
Signed: 05/21/2014 08:06

05/23/2014 ADDENDUM STATUS: COMPLETED
On 5/22/14 I had a phone conversation with Mr. Michael Taub, Esq, staff attorney with the HAP Homeless Advocacy Project. The veteran had requested that I speak with his attorney and explain to him what was discussed in our meeting of 5/20/14. I reviewed the same information provided to the veteran with Mr. Taub and answered his questions. He stated that he would not be assisting the veteran with completion of the SF 95 form. I informed him that if the veteran wants assistance he can speak with his social worker, a veteran organization officer and/or call me.

/es/ SUSANN M KIRLIN, RN
RISK MANAGER
Signed: 05/23/2014 07:42

LOCAL TITLE: SOCIAL WORK NOTE
STANDARD TITLE: SOCIAL WORK NOTE
DATE OF NOTE: MAY 19, 2014@15:36 ENTRY DATE: MAY 19, 2014@15:37:43
AUTHOR: HALSTEAD,DANIEL W EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Casemanager telephoned Mr. Delgado. Casemanager asked Mr. Delgado if he received a telephone call from Ms. Susann Kirlin. Mr. Delgado said no.